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PROVINCE OF ONTARIO

ROYAL COMMISSION

ON

THE WORKMEN'S COMPENSATION ACT

HEARINGS HELD AT  
TORONTO, ONTARIO

VOL. NO.

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11 October 1966

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Nethercut & Young

Toronto, Ontario

IN THE MATTER OF The Public Inquiries  
Act, R.S.O., 1960 Ch. 323

- and -

IN THE MATTER OF an Inquiry Into and  
Report Upon The Workmen's Compensation  
Act

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BEFORE: The Honourable Mr. Justice W.A.  
McGillivray, Commissioner, at  
Room 200, 67 Richmond Street  
West, Toronto, Ontario, on  
Tuesday, 11 October, 1966

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APPEARANCES

W.Z. Estey, Q.C.)	
and )	Counsel to the Commission
H.D. Guthrie )	
L.A. Tufts	Christian Science Church
W. Kennedy)	International Union of Mine,
W. Hall )	Mill and Smelter Workers
J.E. Barnard )	
G. Sawyer )	Ontario Medical Association
B.H. Young )	
A.V. DeJardine	Ontario Osteopathic Assoc.
J.W. Duffy )	Optometrical Association
I. Baker )	of Ontario
D. Lamont Q.C.)	
D.C. Sutherland)	Ontario Chiropractic
E.A. McDonough )	Association
J.W. Ellison )	
C.R. Osler Q.C.)	International Nickel
J. Goodwin )	Company of Canada
W.R. Kerr )	
A.G. Poole )	Workmen's Compensation Board
B. Powell )	

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Toronto, Ontario

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1 At 10:00 a.m., the Hearing commenced.

2 MR. ESTEY: Mr. Commissioner, this morning  
3 we have come to that part of the proceedings announced in  
4 the Notice sent out announcing that we were going to deal  
5 with Medical Matters, generally, including the Board's  
6 relationship with the medical profession, chiropractors,  
7 osteopaths, practitioners under the Chiropody Act, Chris-  
8 tian Scientists, optometrists and related briefs and the  
9 second point, under the heading of Medical Matters, gener-  
10 ally, the question of choice of practitioner.

11 The briefs which have raised this question,  
12 we have covered in alphabetical order and before we start,  
13 I might read this off so that if somebody has been neglected  
14 and wishes to say something which is not in their brief,  
15 which is directed to this question of Medical Matters, they  
16 might speak to either Mr. Guthrie or myself.

17 The chiropodists, the Christian Science  
18 Committee on Publication, International Nickel, Internat-  
19 ional Union of Mine, Mill, Ontario Chiropractic Association,  
20 Ontario Federation of Labour, Ontario Medical Association,  
21 Ontario Osteopathic Association, the Optometrical Associa-  
22 tion, the Retail Council of Canada, the United Electrical  
23 Workers, the United Steel Workers.

24 Mr. Commissioner, in order to proceed as  
25 we have in the past, I propose to take them alphabetically  
26 and to deal with the whole of the topic, Medical Matters,  
27 generally, each time the person appearing for the  
28 organization in question comes before us. The first one  
29 on my list is the brief filed by The Board of Regents,  
30 Chiropody Act (1944), Province of Ontario. Anybody from







1 that Association? The practice we are going to follow is,  
2 those who are not here to present their submissions, we  
3 will read those in at the end of those appearances on this  
4 topic.

5 The next one on this list is the Christian  
6 Science brief on Publications. A brief filed by Mr. Leslie  
7 A. Tufts.

8 THE COMMISSIONER: Yes, Mr. Tufts?

9 MR. TUFTS: Yes, Mr. Commissioner.

10 THE COMMISSIONER: You can proceed as you  
11 see fit. You can follow your brief and read it in or  
12 summarize it as you go along or else you can refer to it  
13 in whatever way you wish.

14 MR. TUFTS: Thank you very much. The brief  
15 is rather short. It is only six and a half pages double  
16 spacing. Would it be all right if I just read it through?

17 THE COMMISSIONER: Yes.

18 MR. TUFTS: The Honourable George A.  
19 McGillivray, Commissioner, The Royal Commission on The  
20 Workmen's Compensation Act, 67 Richmond Street West, Toronto  
21 1, Ontario.

22 Sir: My name is Leslie A. Tufts and I am  
23 the Christian Science Committee on Publication for Ontario.  
24 As spokesman for the citizens of Ontario who adhere to the  
25 Christian Science faith, I would like to thank the Commis-  
26 sion for this opportunity to appear before you to present  
27 the position of Christian Scientists relative to the opera-  
28 tion of the Workmen's Compensation.

29 The Workmen's Compensation Law has been in  
30 existence for a good many years and has benefited both







1 employees and employers. It has provided a very workable  
2 solution to many of the problems of an industrial society.

3           The Workmen's Compensation Law is designed  
4 to benefit employers and employees alike. It provides  
5 that the employer's liability to an employee for damages  
6 or injuries suffered during the course of his employment  
7 shall be assumed by the Workmen's Compensation Board. By  
8 giving up his common law right to sue his employer for  
9 negligence, or to negotiate a settlement, the injured  
10 employee is given two kinds of statutory benefits -- (1)  
11 compensation for disability and loss of wages, and (2)  
12 medical and surgical services to aid in his recovery and  
13 return to work. The cost of the compensation program,  
14 through the medium of insurance premiums paid by the em-  
15 ployer, is passed on by him to the consuming public in the  
16 increased cost of products and services and by deducting  
17 the cost of premiums as a business expense in his Federal  
18 Income Tax return.

19           The Workmen's Compensation Act has never  
20 made provision for those workers who, in good faith, rely  
21 on prayer alone for healing. Thus, under the present ter-  
22 of the law, Christian Science practitioners are excluded  
23 from receiving compensation for their services in giving  
24 healing treatment under the Act. However, I feel confident  
25 that, given the opportunity, the legislators will be glad  
26 to correct this omission.

27           Our legislators have, through the years,  
28 earnestly striven to maintain religious freedom and lib-  
29 erties, and human rights.

30           THE COMMISSIONER:   Is that a correct







1 statement, Mr. Tufts, that you are not compensated out of  
2 the Workmen's Compensation Act for giving treatment?

3 MR. TUFTS: Not to my knowledge, sir. I  
4 know of no cases. As a matter of fact, in my travels around  
5 the Province in giving talks to the members of our churches  
6 the question is often raised by workmen as to when we are  
7 going to receive some adjustment in the Workmen's Compensa-  
8 tion Act which will recognize Christian Science treatment  
9 and care. So I take it from that that nothing is being  
10 received at the present time.

11 THE COMMISSIONER: I see.

12 MR. TUFTS: Our legislators have, through  
13 the years, earnestly striven to maintain religious freedom  
14 and liberties, and human rights, and have spelled them out  
15 in protective statutory provisions. For example, see The  
16 Ontario Human Rights Code, (Statutes of Ontario 1961-62,  
17 Chapter 93). But the present Workmen's Compensation Act  
18 provides an exception to this concept of human rights. Let  
19 me explain the effect it has on Christian Scientists who  
20 are workers. To a Christian Scientist, healing through  
21 prayer is an integral part of his religion; in fact, the  
22 practice of his religion and the healing work are insepar-  
23 able. The teachings and faith of Christian Science do not  
24 employ medical treatment and care for its adherents. Instead,  
25 Christian Science relies wholly and exclusively on the  
26 systematic discipline of Christian healing as set forth in  
27 our denominational textbook. When confronted with an injury,  
28 sickness, or any kind of disability, a Christian Scientist  
29 turns to an accredited Christian Science practitioner for  
30 help. If his condition requires nursing care, he prefers







1 to have the services of a Christian Science nurse who is  
2 trained in caring for the needs of Christian Scientists.  
3 If his condition requires hospitalization, he would want  
4 to be cared for in a Christian Science sanatorium, if one  
5 is available in Ontario, equipped to provide what he needs.  
6 However, in the case of broken bones the Christian Scientist  
7 is prepared to accept the services of a medical practitioner  
8 to set the bone.

9               Christian Scientists turn naturally to God  
10 for healing, as they are accustomed to do, because exper-  
11 ience has demonstrated to them that this is a practical and  
12 effective step. Martyrdom is contrary to the spirit of  
13 Christian Science. The whole import of Christian Science  
14 is that healing is a practical possibility and an integral  
15 part of Christianity. A Christian Scientist wants to be  
16 healed of his injury - to be made whole and to return to  
17 work as rapidly as possible. He has found that for him,  
18 Christian Science is the best way to accomplish this purpose.  
19 As a group, Christian Scientists are generally recognized  
20 to be intelligent, industrious, healthy and responsible  
21 citizens.

22               Since the teachings and faith of Christian  
23 Science do not employ medical treatment and care for its  
24 adherents, it is our hope you will agree that specific  
25 provisions should be made for this group of workers under  
26 the Workmen's Compensation law.

27               Under the common law, which the Workmen's  
28 Compensation Law superseded, no particular type of treat-  
29 ment was prerequisite to the injured employee's receiving  
30 damages for injury although it might have had a bearing







1 upon the measure of damages. Under the present Workmen's  
2 Compensation Law, an employee relying on prayer alone for  
3 healing would be compelled to pay out of his own pocket the  
4 cost of the services of a Christian Science practitioner.

5 I am sure the members of this Commission  
6 will understand that it is a considerable extra hardship  
7 for the Christian Scientist, in endeavoring to work out his  
8 particular injury by prayer alone, to have to submit to the  
9 well-meaning, but to him conflicting services of a physi-  
10 cian, or pay for his own healing treatment. Furthermore,  
11 it is working a considerable additional hardship for the  
12 Christian Scientist to have financial worries added to  
13 his physical disabilities by not receiving payment for his  
14 healing treatment if he does not submit to medical treatment.

15 Workmen's Compensation laws in the States  
16 of Colorado, Connecticut, Florida, Illinois, Indiana,  
17 Louisiana, Minnesota, Missouri, New Jersey, New York, Oregon,  
18 and Wisconsin, either through specific statutes, or admin-  
19 istrative ruling, made provision for those who rely on  
20 prayer alone for healing. These laws have all proved  
21 beneficial to employees and employers alike and have been  
22 successfully administered for many years. Attached are  
23 Xerox copies of letters from administrators of some of  
24 these State laws, affirming the fact that provisions in  
25 Workmen's Compensation laws for Christian Scientists are  
26 workable and successful.

27 On the Federal level, and incidentally,  
28 this is the United States Federal level, Section 222 (b)  
29 (1) of the disability provisions of the Social Security  
30 Act also protects the right of a disabled individual to







1 rely on prayer for healing while drawing disability insur-  
2 ance monthly payments. (See exhibit attached for the text  
3 of Section 222 (b) (1) of the Social Security Act.) Most  
4 recently, when the United States Congress passed the Medi-  
5 care law in 1965 (PL 89-97), they recognized Christian  
6 Science sanatoriums as the equivalent of both medical  
7 hospitals and medical extended care facilities. The Depart-  
8 ment of Health, Education, and Welfare will pay for "hospit-  
9 alization" at a Christian Science sanatorium while an indi-  
10 vidual is receiving treatment from an accredited Christian  
11 Science practitioner on the case just as they will pay for  
12 hospitalization at a medical hospital when a physician is  
13 on the case. (See exhibit attached for the text of Section  
14 1861 (e) and (y).) In addition, attached is a letter from  
15 the Bureau of Family Services affirming that Christian  
16 Science sanatoriums, nursing homes, visiting nurse services,  
17 and private duty nursing may be reimbursed for services  
18 rendered to recipients of State Medical Assistance programs.  
19 All of these services are provided on the basis of certi-  
20 fication of need by Christian Science practitioners.

21 Today, on the basis of the healing record  
22 of Christian Science, hundreds of insurance companies in  
23 the United States recognize and pay for Christian Science  
24 treatment and care in their group health insurance agree-  
25 ments and their various casualty and accident lines. These  
26 companies include Metropolitan Life, and Travelers.

27 On the Federal Insurance level, the Aetna  
28 Life Insurance Company of Hartford, Connecticut, in its  
29 Uniform Plan for Retired Federal Employees, and in its  
30 Government-wide Indemnity Benefit Plan for Active Federal





1 Employees, which covers some five and one-half million  
2 employees and their dependants, provides for Christian  
3 Science treatment and care.

4 Christian Scientists of Ontario are prepared  
5 to furnish satisfactory proof of injury or disability by  
6 submitting to physical examinations. Also, Christian  
7 Scientists would not object to submitting to surgical treat-  
8 ment in the setting of bones in cases of fracture. The  
9 amendment we are proposing will eliminate the present  
10 inequity in the Workmen's Compensation Law in that:

11 It will allow the worker who in good faith  
12 relies solely on treatment by prayer to  
13 rely on this form of treatment exclusively  
14 and to receive his compensation benefits.  
15 The amendment we propose is as follows:  
16 "Nothing in this Act shall be construed  
17 to prevent a workman, whose injury or  
18 disability has been established to the  
19 satisfaction of the employer or directors,  
20 from relying in good faith on treatment  
21 by prayer through spiritual means alone  
22 in accordance with the tenets and  
23 practice of a recognized church or  
24 religious denomination by a duly  
25 accredited practitioner thereof without  
26 suffering loss or diminution of his  
27 compensation benefits under this Act;  
28 and provided further that nothing in  
29 this Act shall be construed to prevent  
30 a workman who desires it from being







1 furnished with such treatment by prayer  
2 through spiritual means alone."

3 The opportunity to make this presentation  
4 before your Commission is sincerely appreciated, and we ask  
5 your sympathetic consideration of the statement and the  
6 amendment proposed therein.

7 That is the end of the brief, sir. If there  
8 are any questions, I will be glad to answer them as best  
9 I can.

10 THE COMMISSIONER: I have examined the  
11 exhibits that you have filed with your submission. The  
12 gist of your submission is that while the workman is not  
13 precluded from seeking the assistance of his church healers,  
14 he receives no compensation for any disbursement in connec-  
15 tion with it, is that right?

16 MR. TUFTS: Yes, sir, that is the founda-  
17 tion of it really, yes. What we are seeking, of course,  
18 is recognition for Christian Science treatment and care  
19 with any added benefits that would be paid in similar cases,  
20 under the medical arrangements. We feel that the compensa-  
21 tion in the cases of where Christian Science treatment and  
22 care are involved should be equivalent to those under the  
23 medical provisions.

24 I think that sums it up, really, in a few  
25 words.

26 THE COMMISSIONER: Mr. Estey may have some  
27 questions.

28 MR. ESTEY: Mr. Tufts, is there any pro-  
29 vision in any other Canadian province to cover the pro-  
30 posal you have made?







1 MR. TUFTS: I think not at the present time.

2 MR. ESTEY: British Columbia had a report  
3 that it went into every conceivable aspect of Workmen's  
4 Compensation and I am surprised to find that there is no  
5 discussion on your question there at all.

6 MR. TUFTS: I think that is something that  
7 well, of course, this Commission has presented an opportunity  
8 for us to submit something here. I am not sure that that  
9 opportunity has occurred in the other provinces.

10 MR. ESTEY: What you are really proposing,  
11 I take it, is that the section dealing with medical aid in  
12 the present statute, be expanded to include the right to  
13 compensation of the Christian Science attendant for the  
14 services rendered?

15 MR. TUFTS: Yes, sir, that is really the  
16 idea.

17 MR. ESTEY: Section 51 says:

18 "Every workman entitled to compensation  
19 under this Part, or who would have been  
20 so entitled had he been disabled for  
21 three days, is entitled to such medical,  
22 surgical and dental aid, the aid of  
23 drugless practitioners registered under  
24 the Drugless Practitioners Act, chirop-  
25 odists, et cetera, and hospital and  
26 skilled nursing services, and, in the  
27 discretion of the Board, where a workman  
28 is rendered helpless through permanent total  
29 disability such other treatment, services  
30 or attendance, as may be necessary as





1 a result of the injury and is entitled  
2 to such artifice member and so on, as  
3 a result of the injury, and to have the  
4 same kept in repair by the Board."

5 I take it that the Board has not made a  
6 practice, up to this point in time, of authorizing treatment  
7 by your Association, your Institution.

8 MR. TUFTS: Not to my knowledge, no.

9 MR. ESTEY: Has this ever been discussed  
10 by the Board as to whether you do come within the present  
11 section 51?

12 MR. TUFTS: Not for quite a long time. I  
13 think there was something presented back in the early 1950  
14 but nothing was accomplished at that time.

15 MR. ESTEY: Did your religious institution  
16 ask the Board, at that time, for some kind of a status or  
17 recognition?

18 MR. TUFTS: I believe so, yes.

19 MR. ESTEY: And nothing came of that?

20 MR. TUFTS: Nothing came of that, no.

21 MR. ESTEY: Can you tell us, so that we can  
22 put this into place along with other submissions for changes  
23 in the Act, is there a tariff or some basis on which the  
24 Board would operate in practice of paying for, as you say  
25 on page 4, "There shall be payment for his healing treatment  
26 Is there any practical basis the Board would have to opera  
27 on that you could direct our attention to?

28 MR. TUFTS: I brought a letter with me  
29 which we prepared, which was prepared by our organization  
30 for the benefit of the insurance field. I will leave a







1 copy of this letter with you. Actually, I should have  
2 submitted it with the brief.

3 MR. ESTEY: Perhaps we could have that  
4 marked as an Exhibit, Mr. Tufts.

5 MR. TUFTS: Yes.

6 EXHIBIT NO. 19: Letter prepared by Christian Science  
7 Committee on Publications entitled  
8 "CHRISTIAN SCIENCE CARE AND TREATMENT"  
9 for the benefit of insurance companies.

10 MR. TUFTS: There is something here:  
11 "Christian Science practitioners, nurses,  
12 and sanatoriums maintain careful records  
13 of those receiving 'necessary hospitaliza-  
14 tion'. Recognizing that Christian Scien  
15 do not make medical diagnoses, insurance  
16 companies accept claim form statements  
17 from Christian Science practitioners  
18 and sanatoriums in layman's terms, to-  
19 gether with other evidence establishing  
20 that treatment and care were necessary  
21 and reimbursement warranted."

22 I thought I had the paragraph here that deals with the  
23 charges. I know it is here. I think, under this title,  
24 "No Concurrent Treatment":

25 "Some insurance claims have included both  
26 the services of physicians and Christian  
27 Science practitioners. But it is standard  
28 practice not to pay for two forms of  
29 treatment for the same period. We feel  
30







1 this is completely reasonable. In accident  
2 cases a Christian Scientist may find him-  
3 self in a medical hospital until he can  
4 make other arrangements. But he does not  
5 expect his benefit plan to pay for both  
6 a physician's charge and Christian Science  
7 practitioner's charge for the same period  
8 of time. In other words, there is no  
9 occasion for 'double payments' even in  
10 those rare cases involving more than one  
11 form of treatment."

12 Well, I haven't just found it here yet but  
13 I know it is in here. There is a reference in here to the  
14 fact that the charges of a Christian Science practitioner  
15 vary on the average between \$3 and \$5 a treatment and we  
16 feel that this would be comparable to the medical charges  
17 in any given area.

18 There is no tariff as such. Each Christian  
19 Science practitioner sets his own fees but it has been  
20 designated by our church authority that these fees should  
21 be on a level with those of reputable physicians in the  
22 same area.

23 MR. ESTEY: Then, Mr. Tufts, is there any  
24 provincial registry of accredited Christian Science prac-  
25 titioners?

26 MR. TUFTS: We have a list of Christian  
27 Science practitioners. We have a directory which is pub-  
28 lished once a month. This occurs in the Christian Science  
29 Journal. In here we have a directory of all approved  
30 Christian Science practitioners, those who have satisfied





1 the requirement of the church as in the case of  
2 and this includes Canada and the Province of Ontario. It  
3 covers practitioners all around the world, Christian Science  
4 practitioners, but there is a section in here which is  
5 devoted to Ontario and the whole of Canada as well.

6 MR. ESTEY: And somewhere does that have a  
7 record of the practitioners in this province?

8 MR. TUFTS: Yes, there is a complete list  
9 of the Ontario Christian Science practitioners.

10 MR. ESTEY: Now, in your brief you refer  
11 to a Christian Science sanatorium. Is there such an insti-  
12 tution available now in the Province of Ontario?

13 MR. TUFTS: No, sir, there is not one  
14 available. We have one coming up and it may be another  
15 six months or it may be a year before this sanatorium  
16 available. Actually, it is a nursing home, a Christian  
17 Science nursing home. We have a sanatorium, only one in  
18 Canada, and this is in Victoria, British Columbia, but we  
19 are hoping that this one in Ontario, this nursing home,  
20 will be in operation in the very near future. Of course,  
21 we have a number of these homes across the border in the  
22 United States. They are establishments which are endorsed  
23 by the Christian Science church as this one in Ontario will  
24 be.

25 MR. ESTEY: Now, one last general topic,  
26 Mr. Tufts. You say in your brief that you really have two  
27 requests to make; one we have dealt with, which is the  
28 right to be treated by your practitioners and to have the  
29 practitioner compensated the same way as other practitioners  
30 are.







1 MR. TUFTS: Yes.

2 MR. ESTEY: And your second one seems to be  
3 and I direct your attention to page 4 of your brief - that  
4 unless the workman who has been injured submits himself to  
5 medical treatment first, that he does not get any compensa-  
6 tion.

7 MR. TUFTS: That was our understanding of  
8 it. If we are wrong on that, we humbly apologize.

9 MR. ESTEY: I am not trying to find out if  
10 you are right or wrong. I wondered what you based that on.  
11 Has that been your experience in practice, that your members  
12 have been unable to get compensation without taking medical  
13 treatment?

14 MR. TUFTS: Well those individuals in our  
15 church who would be classified as workmen and who would  
16 ordinarily be entitled to workmen's compensation benefits  
17 have told me that they have not been successful in obtain-  
18 ing any compensation when they rely on Christian Science  
19 treatment and care.

20 MR. ESTEY: Soley on that without prelimin-  
21 ary medical treatment?

22 MR. TUFTS: Right.

23 MR. ESTEY: You mentioned the setting of  
24 fractures: Is there any other phase of medical treatment,  
25 as we ordinarily use that term, which is accepted?

26 MR. TUFTS: Yes. For example, dental work,  
27 and there is another field which would not come under the  
28 Workmen's Compensation Act, and this is child birth.

29 MR. ESTEY: How about optometric services  
30 or opthomology - eye treatment and so on: Is that in there?





1 MR. TUFTS: What form of treatment would  
2 that be?

3 MR. ESTEY: If a man has to have glasses,  
4 is there any conflict between you and the traditional way?

5 MR. TUFTS: No, not at all.

6 MR. ESTEY: That is not a matter of treat-  
7 ment which is part of your operations?

8 MR. TUFTS: Well, this is a field in which  
9 our healing should be applied more effectively and a lot  
10 of us don't work at it as we should. I recall that ques-  
11 tion being asked of Mr. Hannam, the Editor-in-chief of the  
12 Christian Science Monitor, who was in town here a couple  
13 of weeks ago and who had a great deal of publicity while  
14 he was here, but he said the fault was entirely with him-  
15 self. He wears glasses, and he realized this was something  
16 that he had to work out. Another answer to that question  
17 which comes to me sometimes in speaking to people who are  
18 interested in Christian Science as a group, is that, "When  
19 you were going to school, did you get an A in all subjects?"  
20 Well, of course, they admit definitely not. Well the same  
21 applies to the individual Christian Scientist who wears  
22 glasses. He has not got an A in all categories of his  
23 religious teaching.

24 MR. ESTEY: One last question, Mr. Tufts:  
25 You mentioned some life insurance companies with insurance  
26 contracts available to the public where, I take it, your  
27 practitioners are compensated in the same way as medical  
28 doctors are: Are those policies sold in Ontario, do you  
29 know?

30 MR. TUFTS: They are sold in Ontario mainly







1 by companies of United States origin. I do know of an  
2 occasional individual case, that is, private coverage where  
3 a Canadian insurance company has given compensation where  
4 Christian Science treatment and care has been given, but  
5 the majority of cases on a group basis today is in the  
6 United States company field. For example, the Aetna of  
7 Canada, Metropolitan in Canada and Travelers in Canada and  
8 other United States companies do this. I know that to be  
9 a fact.

10 MR. ESTEY: Thank you very much, sir.

11 THE COMMISSIONER: Thank you, Mr. Tufts.

12 MR. TUFTS: Thank you all very much.

13 MR. ESTEY: Now, Mr. Commissioner, I believe  
14 the International Nickel Company at pages 7 and 13 of their  
15 brief have something, but I am told now they will not  
16 here for the moment, so we will come back to that submission  
17 later.

18 Mr. Kennedy is here for the International  
19 Union of Mine, Mill and Smelter Workers. Do you have  
20 something at page 3 of your brief on this matter, Mr.  
21 Kennedy?

22 MR. KENNEDY: Mr. Commissioner, in our  
23 brief there is considerable material dealing with pre-  
24 existing conditions, neurosis and other matters which are  
25 not covered at the moment, or which have to be dealt with  
26 under another part of the agenda. I don't know if I should  
27 go into all of these matters at this time.

28 MR. ESTEY: The only thing before the Com-  
29 mission today are Medical Matters relating to the Board's  
30 relationship with the medical profession, and so on, as I





1 read it out - those items dealing with silicosis and so on  
2 will come up next week.

3 MR. KENNEDY: Yes.

4 MR. ESTEY: It may be that if there is  
5 nothing which precisely falls under this - we have a note  
6 that you did make some submission, but I am not sure now  
7 that I am right.

8 MR. KENNEDY: I think it would probably  
9 come under the other matters, Mr. Commissioner. While I  
10 am here, and on this particular question, with me today is  
11 Mr. Hall, who handles most of the compensation for our  
12 Union in the Province of Ontario and, without going into  
13 many of the matters of the drugless practitioners, I have  
14 no comment to make to that. I wish to state this, that our  
15 dealings with the medical profession, both locally and with  
16 the Board, have been extremely gratifying to us from the  
17 cooperation we have had from the medical profession. They  
18 don't always tell us what we would like to hear but we feel  
19 that they are doing a good job. The cooperation has been  
20 good as far as we are concerned, and we have very little  
21 complaint with the kind of work that is being done.

22 THE COMMISSIONER: Thank you.

23 MR. ESTEY: We have another note, Mr. Com-  
24 missioner, that the chiropractors who are alphabetically  
25 next, will not be available until half past 11:00. That  
26 takes us in our list to the Ontario Federation of Labour.  
27 Failing any representations from them, we will move onto  
28 The Ontario Medical Association.

29 DR. SAWYER: Mr. Commissioner, dealing with  
30 the question of practitioners, registered under the Drugless







1 Practitioners Act, and chiroprodists, registered under the  
2 Chiroprody Act, in our brief we have said that we approach  
3 this subject with some diffidence as we are aware:

4 1) That a recommendation made by the College  
5 of Physicians and Surgeons of Ontario and our Association,  
6 in a joint presentation to the Enquiry conducted by Mr.  
7 Justice Roach in 1950, that the definition of medical aid  
8 be amended by deleting the words "the aid of drugless  
9 practitioners registered under the Drugless Practitioners  
10 Act" was not accepted; and

11 2) That it was announced by Honourable John  
12 Robarts, Prime Minister of Ontario, during the last session  
13 of the Legislature, that a Committee on the Healing Arts  
14 had been established with terms of reference which included  
15 an examination of "The merit of the services and practice  
16 of all the disciplines associated with the healing arts.

17 27. In these circumstances, we would be sur  
18 prised if any recommendation emanated from this Enquiry  
19 relative to the appropriateness of medical aid, including  
20 the services of drugless practitioners registered under  
21 these Acts. Our decision to comment arose out of our ob-  
22 servation that once a group becomes recognized by statute,  
23 constant pressure is applied to grant members of the group  
24 additional privileges and additional recognition.

25 28. We recommend that any requests for additional  
26 privileges or recognition be refused as it is our considered  
27 opinion that drugless practitioners registered under these  
28 Acts do not possess sufficient medical knowledge to enable  
29 them to make a complete assessment of an injured workman.

30 That is the end of that portion of the brief





1 MR. ESTEY: Are you going on to cover other  
2 parts in your brief?

3 DR. SAWYER: I thought this was the first  
4 part of what was on the agenda this morning, and then we  
5 have a comment on the second part. Do you want me to  
6 take that now?

7 MR. ESTEY: I think it would be more con-  
8 venient if you did it all at one time.

9 DR. SAWYER: This has to do with the choice  
10 of physician, on page two of our brief:

11 5. FREEDOM OF CHOICE OF PHYSICIAN

12 The Workmen's Compensation Act gives the  
13 Board the right to determine who shall provide medical  
14 services to those for whom it has responsibility under the  
15 Act. Without abrogating this right, the Board has allowed  
16 an injured workman the freedom of initial choice of his  
17 physician. At any time during the period of the workman's  
18 disability, the Board has the authority to transfer the  
19 workman to the care of another physician regardless of the  
20 desire of the workman and/or his physician. In the vast  
21 majority of cases, this authority is not invoked and the  
22 same conditions prevail as in the private practice of  
23 medicine.

24 6. Transfer of patients is usually made because  
25 the Board has decided that workmen with certain conditions  
26 must be treated by those physicians who have specialist  
27 qualification granted by the Royal College of Physicians  
28 and Surgeons of Canada in a specialty designated by the  
29 Board for the care of the condition in question. There is  
30 no doubt that this policy has provided injured workmen with







1 a good quality of medical services. That is not to say  
2 that the quality would not be equally good if the attend-  
3 ing physician and the workman made the decision as to  
4 choice of physician.

5 7. The ordinary citizen not coming under the  
6 jurisdiction of the Workmen's Compensation Act is subject  
7 to the same conditions as workmen for whom the Board is  
8 responsible. These citizens have free choice of physician  
9 throughout the period of their disability and in our opin-  
10 ion they are provided with an excellent quality of medical  
11 services.

12 8. The Council of our Association, in discussing  
13 the principles involved, concluded that the physician  
14 chosen by the patient was more likely to guide the patient  
15 to a higher quality of medical services because of his  
16 personal interest in his patient's welfare and the day-to-  
17 day knowledge of the abilities of his colleagues. This  
18 conclusion was set out in our Policy Statement, as follows.

19 "The individual citizen must have the  
20 right of freedom of choice of doctor  
21 and freedom of choice of hospital  
22 within the limits of safety to others."

23 9. We recommend that the Act be amended to  
24 state clearly that those coming under the jurisdiction of  
25 the Board have freedom of choice of doctor.

26 THE COMMISSIONER: As I understand it, you  
27 say they already have that freedom of choice?

28 DR. SAWYER: Initially.

29 THE COMMISSIONER: Your recommendation is  
30 that so long as possible, the treatment remain in the hands





1 of that doctor or specialist whom he might have gone to?

2 DR. SAWYER: That is right.

3 THE COMMISSIONER: In other words, they  
4 would be kept more on what might be called the grass roots  
5 level, the decision-making as to whether he is fit to  
6 return or what the treatment should be.

7 DR. SAWYER: Well, keeping it on the same  
8 level as in the present practice of medicine.

9 I think those are the two sections which  
10 cover what is on the agenda today.

11 MR. ESTEY: There are one or two things we  
12 would like to find out from you, doctor, while you are here.  
13 One of them is, where does the proceedings before the  
14 Committee on Healing Arts stand now?

15 DR. SAWYER: The Committee has been estab-  
16 lished and it's had the preliminary Hearing. Briefs are  
17 supposed to be in by the 1st of December and they said  
18 they would likely start Hearings sometime in December.  
19 They hope to finish by February.

20 MR. ESTEY: I take it that your last ref-  
21 erence is to section 51 of the Act which says in part that  
22 all questions as to the necessity, character and sufficien-  
23 cy of any medical aid furnished or to be furnished and as  
24 to payment for medical bills shall be determined by the  
25 Board. That is the section on which the Board relies, I  
26 take it, when they say that this man now should come under  
27 the services of an orthopaedic surgeon or some other  
28 specialist.

29 DR. SAWYER: That is correct.

30 MR. ESTEY: So that we will understand your







1 submission completely, are you saying that that section  
2 should be amended or that it should be interpreted and  
3 applied in a different way by the Board, so as to assure  
4 the workman of his basic right to not only the initial  
5 physician selection but also to the specialist to whom he  
6 would be referred?

7 DR. SAWYER: I don't think the section  
8 needs to be amended. I think it is in the application.

9 MR. ESTEY: You think it is in the policy  
10 adopted by the Board under that section, and you say it  
11 should afford the workman a greater choice through his  
12 attending physician before the Board says what shall be done?

13 DR. SAWYER: That is correct.

14 MR. ESTEY: In practice does the Board in-  
15 terfere if that word is not too strong, or invoke this  
16 procedure frequently or infrequently?

17 DR. SAWYER: I would say infrequently.

18 MR. ESTEY: So I take it that your observa-  
19 tions in your brief, while they relate to that point, are  
20 not to be taken as describing an alarming situation or one  
21 which has arisen frequently.

22 DR. SAWYER: I think the concern of our  
23 Board, Mr. Estey, was that we did not want the power which  
24 the Board has to be applied much more frequently than it  
25 is now. We don't want it to have a trend toward the Board  
26 designating physicians for every Workmen's Compensation  
27 claimant.

28 MR. ESTEY: So far as the choice of doctor  
29 is concerned, in practice I take it that what happens in  
30 the routine accident, a workman who is hurt but not disabled





1 or rendered unconscious, he leaves his place of work and  
2 goes to his doctor, the ordinary family doctor, and from  
3 there on the doctor files reports with the Board and he  
4 progresses to other medical treatment as the nature of the  
5 injury warrants. That is the general practice, I take it?

6 DR. SAWYER: That is correct.

7 MR. ESTEY: When he goes to his family  
8 doctor, we have heard a lot of discussion about how the  
9 doctor fills out forms and sends them in and in that form  
10 he says when the man should be going back to work; he  
11 describes the history of the accident as he hears it from  
12 his patient, and all the other things that form number 7  
13 requires the doctor to report upon. My question to you,  
14 Dr. Sawyer, is this: Does your Association find that the  
15 relationship which the Act requires as between a doctor  
16 and his patient is, in any way, inconsistent with the  
17 normal doctor-patient relationship?

18 DR. SAWYER: From what members of the  
19 Association tell me -- and I am not in practice -- you get  
20 into some peculiar situations where a doctor will be able  
21 to look after someone who is quite severely injured,  
22 because he is severely injured. Then, perhaps the next  
23 day he will have an elective situation to take a small  
24 cyst off a wrist or something like that, and he will not  
25 be allowed to do that because he does not have a certifi-  
26 cate from the Royal College of Physician and Surgeons to  
27 do that particular thing, although the previous day he may  
28 have treated something twice as difficult. So it is the  
29 application of rules, I think, that bothers some of our  
30 people, because you must realize that in certain hospital







1 doctors, because of their length of experience and training,  
2 might have full surgical privileges although they do not  
3 have a certificate from the Royal College of Physicians  
4 and Surgeons. And the doctors in that community would  
5 ordinarily refer their surgical problems to this particular  
6 surgeon. But, under some of the rules of the Compensation  
7 Board, as I understand it, there are certain situations  
8 where they would not allow him to do it because he did not  
9 have a certificate of the Royal College.

10 MR. ESTEY: In other words, he would be  
11 qualified in the hospital where the workman is located but  
12 he would not have his Royal College certificate so that the  
13 Board would say that another doctor must look after that  
14 man.

15 DR. SAWYER: That is right.

16 MR. ESTEY: And if the man doesn't want  
17 that other doctor, I suppose there is a conflict, he has  
18 to take the other doctor because he is getting the medical  
19 aid paid for by the Board?

20 DR. SAWYER: That is my understanding. If  
21 he does not take the doctor designated by the Board - and  
22 it may not be one doctor, they may give them a choice of  
23 three or something of that sort, but if he does not accept  
24 that, then I understand his compensation will not be paid.  
25 That is my understanding.

26 MR. ESTEY: Do you have any practical  
27 difficulties in your course of the conduct of medicine in  
28 this province, as known to your Association arising out of  
29 the fact that the doctor, in the case of an injured workman  
30 releases information to the Workmen's Compensation Board





1 which normally is known only to himself and his patient?

2 DR. SAWYER: Well, this is covered under  
3 the Act, I believe, sir, that the Compensation Board can  
4 request information and the patient, in seeking compensation,  
5 automatically --

6 MR. ESTEY: .... submits to the process?

7 DR. SAWYER: That is correct.

8 MR. ESTEY: So anything that flows from  
9 that, in practice, is taken for granted because of the  
10 whole compensation scheme.

11 DR. SAWYER: That is correct.

12 MR. ESTEY: And gives rise to no difficulties  
13 to your profession so far as the administration of the  
14 Workmen's Compensation plan is concerned.

15 DR. SAWYER: I have not heard of one in the  
16 fifteen years I have been with the Association.

17 MR. ESTEY: Thank you very much, Doctor.

18 THE COMMISSIONER: You have some associates  
19 with you, Dr. Sawyer. Does anyone else wish to say anything  
20 on the matter?

21 DR. SAWYER: They say not, sir.

22 THE COMMISSIONER: Thank you.

23 MR. ESTEY: Mr. Commissioner, a brief by  
24 the Ontario Osteopathic Association.

25 MR. DeJARDINE: I am A.V. DeJardine, I am  
26 President of the Ontario Osteopathic Association.

27 This brief is presented by the Ontario Osteo-  
28 pathic Association, representing the osteopathic physicians  
29 practicing in the Province of Ontario.

30 We apologize for the late filing of this







1 but the first notice this Association had of the  
2 of their Commission was a news report in the press on  
3 August 17, 1966, the day following the deadline for filing  
4 reports.

5 What is the osteopathic profession? At the  
6 end of 1965, the osteopathic profession consisted of  
7 16,743 physicians, all but 193 living in the United States  
8 of America. Approximately 12,000 of these are in active  
9 practice. In forty of these States the members of the  
10 osteopathic profession are fully licenced to practice  
11 medicine. There are only 213 osteopathic physicians in  
12 the remaining ten States, thus only 1.81 per cent of all  
13 the practising osteopathic physicians in the United States  
14 are in States where there is any limitation of their prac-  
15 tice of medicine. It is estimated that the osteopathic  
16 profession is handling the total health needs of between  
17 8 per cent and 10 per cent of the population of the United  
18 States of America; equivalent in number to the population  
19 of Canada.

20 The osteopathic physicians in Ontario have  
21 had exactly the same education and training as those in  
22 the United States, because the osteopathic colleges are all  
23 in the United States. Admission to an osteopathic college  
24 requires at least three years of university pre-medical  
25 education. The medical course in the osteopathic colleges  
26 consists of four academic years totalling approximately  
27 forty months. This is considerably longer than the period  
28 of time spent in a medical course in Ontario, since osteo-  
29 pathy takes nothing away from the teaching or practice of  
30 medicine but adds something of great worth to the patient.





1 In fact we have more to teach. 99 per cent of the graduates  
2 will complete a twelve month rotating internship before  
3 commencing practice. Some will continue their education  
4 for another three to five years and be certified in one of  
5 the medical specialties.

6 In the light of the above facts it was im-  
7 pertinent of the Ontario Medical Association to recommend  
8 to this Commission as quoted in the Globe and Mail of  
9 August 17, 1966, and reiterated here just a few moments  
10 ago by Dr. Sawyer:

11 "The O.M.A. recommended that drugless  
12 practitioners (such as osteopaths)  
13 should not be granted any additional  
14 privileges or recognition. These  
15 persons lack sufficient medical know-  
16 ledge to enable them to make a complete  
17 assessment of an injured workman, the  
18 brief said."

19 On the contrary, because of the osteopathic  
20 physician's additional education and training in the field  
21 broadly known as Physical Medicine and the fact that he  
22 has been forced to specialize in this field in Ontario  
23 because of the short-sighted inclusion of him under The  
24 Drugless Practitioners Act, notwithstanding his medically  
25 oriented practice, he is more capable than any other to  
26 assess many physical injuries suffered by workmen, particu-  
27 larly in the light of his medically oriented practice.

28 The Ontario Osteopathic Association there-  
29 fore submits:

30 That the workman be allowed to make his own





1 free choice of physician in the first instance, as is pre-  
2 sently the policy, but also be allowed to change physician  
3 after a reasonable time by expressing his dissatisfaction  
4 with the medical treatment he is receiving to the Board.

5 THE COMMISSIONER: Now, on that one, when  
6 you say, "free choice of a physician" you are referring to  
7 an osteopath?

8 MR. DeJARDINE: Yes, sir. It is suggested  
9 that the initial choice the workman can make can be those  
10 covered under the Drugless Practitioner's Act, an MD and  
11 so on.

12 THE COMMISSIONER: He is allowed to do  
13 that now.

14 MR. DeJARDINE: He is allowed initially,  
15 to make the first choice.

16 THE COMMISSIONER: And payment is made for  
17 these services?

18 MR. DeJARDINE: Yes, sir. But we are sug-  
19 gesting that after a reasonable period of time, he should  
20 be allowed, by expressing his dissatisfaction, to go to  
21 another physician as a person would in ordinary circum-  
22 stances, dealing with his doctor.

23 2. That the Workmen's Compensation Board en-  
24 courage workmen who suffer low back injuries or so-called  
25 disc problems, to consult osteopathic physicians within  
26 a reasonable period of time so that a competent evaluation  
27 of the physical structure may be done and, where possible,  
28 treatment instituted to normalize the structures offending  
29 before the patient reaches the stage where rehabilitation  
30 is the only recourse, with its connotations of maintainin







1 an abnormal status quo, but helping the workmen to learn  
2 to live more comfortable. It is not suggested at this  
3 time that osteopathic physicians be employed by the Board's  
4 Rehabilitation Centre, for one reason there is a shortage  
5 of osteopathic physicians in the province because of the  
6 restrictive practice legislation, and for another, the  
7 workman can best be served if he is treated in the osteo-  
8 path physician's office well before he reaches the stage  
9 where rehabilitation is the last resort.

10 3. That the osteopathic physician be allowed  
11 bill the patient directly and that recompense be made  
12 by the Board to the patient. It is strongly recommended  
13 that the Board revise the fees paid for osteopathic services  
14 by taking into consideration the specialized work involved  
15 which is much more time consuming than treatment generally  
16 administered to the workman by a medical physician. At  
17 present, osteopathic physicians are paid according to a  
18 schedule based on the Ontario Medical Association fee  
19 schedule. Over the years a number of osteopathic physicians  
20 have discontinued subsidizing the Medical Aid Division of  
21 the Compensation Board in this way, while others handle  
22 Compensation cases as charity work at a reduced fee. The  
23 result is that some workmen are being deprived of the  
24 ~~services~~ services they require and employers who are pro-  
25 viding the funds for these services are not having their  
26 employees receive the competent care they deserve.

27 THE COMMISSIONER: What is the purport of  
28 that paragraph? When you say that it involves more time,  
29 t. what do you refer, I mean in what way?

30 MR. DeJARDINE: There is more time involved





1 in treatment, diagnosis, differential diagnosis with the  
2 patient than is often the case with normal medical treat-  
3 ment. There is more time and the osteopath cannot have  
4 the same patient load, for instance, in the course of a  
5 day as the average MD might be able to have and we feel  
6 that the fees paid at the present time by the Compensation  
7 Board are not adequate.

8 THE COMMISSIONER: It is not in the field  
9 of treatment but in the field of diagnosis that you feel  
10 that you are not adequately compensated?

11 MR. DeJARDINE: Well, you can't treat unless  
12 you diagnose properly and treatment follows diagnosis. We  
13 feel that the amount of time that is involved with the  
14 patient each time we may see him, is not compensated for  
15 fully.

16 MR. ESTEY: Would you tell me, first of  
17 all, I would like to go back to the beginning and find out  
18 a little more about this before I come down to your pro-  
19 posals. First of all, you say that you represent osteo-  
20 pathic physicians practicing in Ontario. How many practice  
21 in Ontario, to start with?

22 MR. DeJARDINE: There are approximately  
23 65

24 MR. ESTEY: And they are registered under  
25 the Drugless Practitioners Act?

26 MR. DeJARDINE: Yes, we are registered  
27 under the Drugless Practitioners Act.

28 MR. ESTEY: In the course of your practice,  
29 through your Association or otherwise, is there a tariff  
30 of fees which is published and which would be available to us?







1 MR. DeJARDINE: Yes.

2 MR. ESTEY: Do you have a copy with you?

3 MR. DeJARDINE: I don't have a copy but I  
4 could get you one.

5 MR. ESTEY: Will you send us one?

6 MR. DeJARDINE: Yes.

7 MR. ESTEY: Just to refer to your numbers  
8 again, these men are all trained in the United States  
9 because you have no training facilities here?

10 MR. DeJARDINE: There are no colleges here.

11 MR. ESTEY: I take it that is true in all  
12 the other provinces in Canada as well?

13 MR. DeJARDINE: That is right, yes.

14 MR. ESTEY: Under the Workmen's Compensa-  
15 tion Act elsewhere in Canada, do you have a different  
16 status than you have here, or is it about the same?

17 MR. DeJARDINE: I am afraid I could not  
18 say, sir. The restrictions, the rights that the profession  
19 has as far as practice is concerned, varies from province  
20 to province. This is under provincial jurisdiction. The  
21 same thing happens in the United States. There are a few  
22 places in the United States where there are a few restric-  
23 tions on the practice of medicine by our profession. In  
24 Canada there are restrictions in all the provinces in  
25 Canada where our profession is licenced, although in all  
26 provinces west of Ontario, the restrictions are consider-  
27 ably less than those here in Ontario.

28 MR. ESTEY: I don't want to get into the  
29 professional aspect of it. You answered my question dealing  
30 with Workmen's Compensation Board treatments of this problem





1 across Canada and you don't know the answer to that?

2 MR. DeJARDINE: No.

3 MR. ESTEY: Now also, without getting into  
4 the scientific side of things, you say that your training  
5 is comparable to that of the medical practitioner except,  
6 as I read your brief, you say your training period is  
7 longer.

8 MR. DeJARDINE: Yes, sir.

9 MR. ESTEY: I take it that they are both  
10 four year courses but you get more months of instruction  
11 in any year than the medical profession.

12 MR. DeJARDINE: This is right. Generally  
13 speaking the medical schools in the United States have a  
14 longer school year, actually, than they have here in Ontario.  
15 The osteopathic school year is even a little longer than  
16 the average medical course in the United States.

17 MR. ESTEY: In the administration of the  
18 treatment of injuries by the Board, you say that you are  
19 accorded the same financial status, if I might refer to it  
20 that way, as the medical practitioner.

21 MR. DeJARDINE: I don't quite follow your  
22 question.

23 MR. ESTEY: Your fee structure, as admin-  
24 istered by the Board is the same as the doctors receive?

25 MR. DeJARDINE: This is my understanding,  
26 this is what the fee is based on, yes.

27 MR. ESTEY: And the treatments which are  
28 comparable on the medical side, I take it, are those treat-  
29 ments administered by general practitioners or internists,  
30 that is the scale that you are accorded by the Board?





1 MR. DeJARDINE: The general practitioners'  
2 fee, not any form of specialist fee at all.

3 MR. ESTEY: That is what I want to get at.  
4 You are on a general practitioner's scale. And then, as  
5 I understand you, you say that not only is that so, but  
6 the volume of treatment per capita, per patient, is lower  
7 in an osteopath's day than in a general practitioner's  
8 average day.

9 MR. DeJARDINE: We require more time with  
10 a patient, generally speaking, yes.

11 MR. ESTEY: And the Board compensates you  
12 not on a time basis but on a treatment basis?

13 MR. DeJARDINE: The number of times you  
14 see the patient, yes.

15 MR. ESTEY: Has your Association taken  
16 this matter up with the Board in recent years?

17 MR. DeJARDINE: Yes, our Association has  
18 made a number of appearances before the Board, suggesting  
19 that they revise ~~their~~ fee schedule as it applies to us  
20 and, in each instance they say, "Well, we have to lump  
21 all of you under the Drugless Practitioners Act the same  
22 way", for some reason or other and they have decided that  
23 they will pay us the same fee as what they pay the MD.

24 MR. ESTEY: And that has been the practice  
25 for some time, I take it?

26 MR. DeJARDINE: I think as far back as  
27 the Compensation Board has been accepting our work.

28 MR. ESTEY: And how long is that now?

29 MR. DeJARDINE: I don't know. I don't  
30 think it has been since the inception of the Board, but







1 would be before my time.

2 MR. ESTEY: A long time?

3 MR. DeJARDINE: Yes.

4 MR. ESTEY: And I take it this whole matter  
5 of professional status and the relationship between the  
6 two professions is the subject of an examination by this  
7 Healing Arts Commission we have heard about?

8 MR. DeJARDINE: Yes.

9 MR. ESTEY: And you will be appearing  
10 before that?

11 MR. DeJARDINE: Yes, we will appear.

12 MR. ESTEY: On your first proposal on page  
13 3 of your brief, as I understand it, the injured workman  
14 has a free choice to go to a medical doctor or an osteo-  
15 path or somebody else in the first instance.

16 MR. DeJARDINE: That is right.

17 MR. ESTEY: Unless, of course, he is  
18 knocked unconscious or something and he doesn't have any  
19 choice, but for the ordinary run-of-the-mill injury, he  
20 can elect to go to you or to a doctor registered under the  
21 Medical Act, or through a chiropractor or somebody else,  
22 there is no problem in that connection?

23 MR. DeJARDINE: There is no problem there.

24 MR. ESTEY: And I take it after the man  
25 has been treated by whoever he has first selected, that  
26 on occasion the Board says that this man would be further  
27 advanced medically if he went to doctor X.

28 MR. DeJARDINE: Yes.

29 MR. ESTEY: And I take it at that point  
30 you have no objection either?





1 MR. DeJARDINE: Only to the point that I  
2 don't know if it is part of the regulations of the Board  
3 that are constantly adhered to, but as far as it applies  
4 to our profession, they have a 14 day period in which, if  
5 the workman is not completely better within a period of 14  
6 days, we must receive permission from the Board to continue  
7 treatment. This is somewhat resented by a number of our  
8 practitioners. We feel it is reflecting on possibly our  
9 competence.

10 MR. ESTEY: I don't mean to cut you off,  
11 but you said something that interested me, there. In the  
12 ordinary run-of-the-mill case, I take it treatment goes  
13 beyond the 14 day period?

14 MR. DeJARDINE: Not necessarily, but the  
15 cause for the injury, many of the injuries that we will  
16 see, may have had its beginnings farther back than when the  
17 actual accident happened and it may not be a matter of --

18 MR. ESTEY: What happens at the end of the  
19 14 day period?

20 MR. DeJARDINE: We have to beg the Board  
21 to let us treat them.

22 MR. ESTEY: How do you do that, write a  
23 letter to the Board?

24 MR. DeJARDINE: Write a letter to them or  
25 they can be phoned.

26 MR. ESTEY: And in practice, does the Board  
27 in the ordinary case, authorize you to carry on, or is it  
28 a rare case that they authorize you to carry on?

29 MR. DeJARDINE: It varies. From stories  
30 we hear from various practitioners some of them seem to







1 have a certain amount of trouble and others don't seem to  
2 have too much trouble.

3 MR. ESTEY: Do most of your 65 members  
4 practice in and around Metropolitan Toronto?

5 MR. DeJARDINE: No, they are scattered  
6 rather thinly in many parts of the province.

7 MR. ESTEY: So that some of them would  
8 have to get that authority by mail?

9 MR. DeJARDINE: Yes, or long distance  
10 telephone.

11 MR. ESTEY: And I take it that on occasion  
12 the Board denies the approval to carry on?

13 MR. DeJARDINE: It has the right to and  
14 this is implied.

15 MR. ESTEY: Of course it is expressed in  
16 the Act that they have a right to.

17 MR. DeJARDINE: Yes.

18 THE COMMISSIONER: Of course, it can be  
19 denied to an ordinary medical practitioner too?

20 MR. DeJARDINE: I can't deny that, but I  
21 don't think they have to, every fourteen days, check with  
22 the Board, as we do, to continue treatment.

23 MR. ESTEY: It is every fourteen days?

24 MR. DeJARDINE: Yes.

25 MR. ESTEY: You don't get a permit of  
26 longer than 14 days duration at any time?

27 MR. DeJARDINE: Fourteen days from the  
28 time of the injury to the workman and we may not see the  
29 workman for two or three or four days.

30 MR. ESTEY: And after you have treated him





1 and run out of the fourteen days, you may get an extension  
2 for another fourteen days?

3 MR. DeJARDINE: Or you may not.

4 MR. ESTEY: But at the end of the second  
5 fourteen day period you have to go back and get further  
6 approval to carry on?

7 MR. DeJARDINE: Yes.

8 MR. ESTEY: Then, I take it you are saying  
9 that on occasion the Board, perhaps without reference to  
10 the fourteen day period, elects to send the man to another  
11 type of practitioner?

12 MR. DeJARDINE: Yes.

13 MR. ESTEY: Does it ever happen in reverse  
14 that the Board elects to send an injured workman who is  
15 under treatment from a medical doctor to one of your members?

16 MR. DeJARDINE: I have never known it to  
17 happen. I think it should happen but I have never known  
18 it to happen.

19 MR. ESTEY: Do you have anything to say as  
20 to what the policy or practice of the Board is when an  
21 injured workman asks to be permitted to transfer to an  
22 osteopath? What does the Board do?

23 MR. DeJARDINE: I have never heard of this  
24 situation coming up. I would be inclined to think they  
25 would probably say no.

26 MR. ESTEY: The reason I am asking you  
27 these questions is that your first proposal is that the  
28 workman be allowed to make his own free choice of physician  
29 in the first instance. He can do that.

30 MR. DeJARDINE: Yes.





1 MR. ESTEY: But the next part says "but  
2 also be allowed to change physicians after a reasonable  
3 time by expressing his dissatisfaction". Do you have any  
4 cases where the Board has denied the right to change?

5 MR. DeJARDINE: We have had patients who  
6 have come to us covered by compensation who have been treated  
7 for a condition, possibly with a medical doctor, and after  
8 a period of time they have not been satisfied themselves  
9 with the treatment they were getting and they have sought  
10 our attention, and the Board will not cover them for this  
11 because the Board has not given their permission for this  
12 transfer to take place. This recommendation we make is  
13 suggesting the workman can function the same way toward  
14 his medical practitioner whether it be an MD or an osteo-  
15 path or what have you, as he would normally.

16 MR. ESTEY: That is why I want to be clear  
17 You are saying that on occasion injured workmen do ask to  
18 be transferred to an osteopath from some other type of  
19 treatment and that the Board does not accept this request.

20 MR. DeJARDINE: I cannot prove this, sir,  
21 but I am almost certain this does happen. I have heard of  
22 a number of cases where it has happened.

23 MR. ESTEY: It is on that belief that the  
24 number one proposal sits?

25 MR. DeJARDINE: Yes.

26 MR. ESTEY: Now we move on to number two:  
27 As I understand this second proposal it is that in the  
28 case of these back injuries that the osteopathic physicians  
29 be consulted within a reasonable period of time so that they  
30 can diagnose the problem before it becomes so serious that







1 rehabilitation will be required?

2 MR. DeJARDINE: Yes. We feel that in this  
3 field -- and this is just given as an example -- naturally  
4 the way we are restricted in the Province of Ontario under  
5 the provisions of the Drugless Practitioners Act, there are  
6 many injuries that workmen have that we cannot do anything  
7 with; we are not allowed to -- lacerations, broken bones  
8 and so on. But there are certain conditions, especially  
9 physical strains and so on, where we feel we have a con-  
10 siderable amount to offer. This is one example, the problem  
11 of back conditions.

12 MR. ESTEY: But I want you to be as precise  
13 as you can on this proposal: Are you saying in your second  
14 proposal that whether or not the workman elects to take  
15 treatment from your members that the Board might on occasion  
16 refer a member to the osteopathic profession.

17 MR. DeJARDINE: This is what we are sug-  
18 gesting. We are suggesting that, if in the rules of the  
19 Board they have the option of checking on what a doctor is  
20 doing, and after a period of 14 days we are suggesting  
21 that, in these types of cases, that possibly the Board  
22 should consider sending the workman to an osteopath.

23 MR. ESTEY: I take it there are no osteo-  
24 paths in the Board itself?

25 MR. DeJARDINE: No.

26 MR. ESTEY: In the treatment sections of  
27 the Board, they have none of your members?

28 MR. DeJARDINE: No, not at all.

29 MR. ESTEY: So what you are asking in the  
30 second proposal is that you be put in the same position as





1 say, a specialist may be in the medical profession so that  
2 when the treatment has not resulted in the expected recovery  
3 that he might be consulted.

4 MR. DeJARDINE: Yes. We are functioning  
5 basically as specialists here. We cannot carry on a general  
6 practice. We are functioning in a fairly limited specialist  
7 field.

8 MR. ESTEY: In your item number three, you  
9 say the osteopathic physician be allowed to bill the patient  
10 directly and that recompense be made by the Board to the  
11 patient. How does it work now?

12 MR. DeJARDINE: When a treatment is con-  
13 cluded, certain forms are filled out for the Board and  
14 sent into the Board and the Board sends back -- pays you  
15 according to their fee schedule.

16 MR. ESTEY: Under your proposal you don't  
17 want to bill the Board: You want to bill the patient.

18 MR. DeJARDINE: Handle it very much in the  
19 same way that cases will be handled with insurance coverage  
20 of various kinds.

21 MR. ESTEY: I take it that the real sub-  
22 stance of the proposal is, though, that you would bill the  
23 patient according to your own scale of fees and then the  
24 patient would be reimbursed on that scale rather than the  
25 scale the Board now use in payment of your profession.

26 MR. DeJARDINE: That is true, although we  
27 also think the Board should revise its thinking on the  
28 fees paid for our services.

29 MR. ESTEY: But I take it that the real  
30 nub of your proposal is not the mechanics of billing, the







1 route the bill takes, but the quantum of the bill.

2 MR. DeJARDINE: No, I think the route has  
3 something to do with it. I think actually this is the way  
4 the Board functions, that the patient is the patient of  
5 the Board rather than the patient of any given doctor. This  
6 is one of the situations in practice where the patient is  
7 not really your patient; he is the patient of the Board  
8 and you, as the physician, have certain limitations on what  
9 you can have that patient do. Just as Dr. Sawyer said, the  
10 general practitioner cannot decide to send a patient to  
11 this place or that place to get the best care without run-  
12 ning into problems.

13 MR. ESTEY: He can recommend it but he  
14 can't decide it?

15 MR. DeJARDINE: He can't decide it.

16 MR. ESTEY: Your proposal is two-fold, then,  
17 firstly that the fees payable to you should be greater than  
18 a general practitioner for reasons you have given us and  
19 secondly, you think your practitioner-patient relationship  
20 suffers by reason of the intervention of this third party  
21 Board in between the two.

22 MR. DeJARDINE: Yes, sir.

23 MR. ESTEY: In that connection does the  
24 osteopath fill out the forms in the first instance that  
25 the Board requires when the workman first comes to him in  
26 the same way that the medical doctor does?

27 MR. DeJARDINE: Yes. I believe the medical  
28 forms are fairly standard.

29 MR. ESTEY: In some cases you would fill  
30 out form 7, submit it and conduct the correspondence with





1 the Board, the Board would pay your fee and that would be  
2 the end of it?

3 MR. DeJARDINE: That is right, sir.

4 MR. ESTEY: And you experience no difficulty  
5 in your dealings with the Board so far as that part of your  
6 operation is concerned?

7 MR. DeJARDINE: Oh, no.

8 MR. ESTEY: I take it that you do not find  
9 any difficulty in that connection caused by the fact the  
10 Board pays you rather than the workman.

11 MR. DeJARDINE: Not particularly, no.

12 MR. ESTEY: And I take it you are in the  
13 same position as the medical doctor that, where the Board  
14 does not accept the claim for compensation, you must look  
15 to the patient for your payment and not to the Board.

16 MR. DeJARDINE: That is right.

17 MR. ESTEY: That is the normal thing?

18 MR. DeJARDINE: Yes.

19 MR. ESTEY: And that happens in your pro-  
20 fession as well as the others.

21 MR. DeJARDINE: Yes, of course.

22 MR. ESTEY: Thank you very much.

23 THE COMMISSIONER: Thank you.

24 I think we will adjourn now for a few  
25 minutes before we start the next witness.

26 Short recess.

27

28 MR. ESTEY: Mr. Commissioner, there has  
29 been a brief filed by the Optometrical Association of  
30 Ontario, and we would now like to call upon them for their





1 submissions.

2 THE COMMISSIONER: What is your name, please?

3 MR. DUFFY: My name is James Duffy and I am  
4 presenting a very short brief on behalf of the Optometrical  
5 Association of Ontario:

6 Purpose of Submission: to recommend that  
7 the words "Optometrical Aid" be included in Section 51 (i)  
8 and (ii) of the Workmen's Compensation Act, so that this  
9 aid, already provided, is established by definition.

10 That is the whole purpose of this submission.

11 1. For many years, optometrists have provided  
12 vision services to workmen entitled to compensation under  
13 the Workmen's Compensation Act.

14 2. These services are presently made available  
15 and paid for by procedures provided for in Form 192 - Opto-  
16 metrical Services, a copy of which is attached.

17  
18 3. Other optometrical procedures may be necessary  
19 for injured workmen and entitlement for such procedures is  
20 first established by the Workmen's Compensation Board and  
21 permission given or referral made for the particular procedure

22 4. At present, The Workmen's Compensation Act  
23 does not specifically provide for Optometrical Aid by defin-  
24 ition, although in fact, such aid is provided. It is recom-  
25 mended therefore, that Section 51 of the Statute be amended  
26 to include the words "optometrical aid".

27 5. The section would then read:

28 "51 - (i) - Every workman entitled to  
29 compensation under this Part, or who would  
30 have been so entitled had he been disabled







1 for three days, is entitled to such medical,  
2 surgical, dental and optometrical aid, the  
3 aid of drugless practitioners registered  
4 under The Drugless Practitioners Act, the  
5 aid of chiropodists registered under the  
6 Chiropody Act, and hospital and skilled  
7 nursing services, and, in the discretion of  
8 the Board where a workman is rendered help-  
9 less through permanent total disability,  
10 such other treatment, services or attendance  
11 as may be necessary as a result of the  
12 injury, and is entitled to such artificial  
13 member or members and apparatus and dental  
14 appliances and apparatus as may be necessary  
15 as a result of the injury, and to have the  
16 same kept in repair or replaced when deemed  
17 necessary by the Board, R.S.O. 1960, c.437;  
18 1962-63, c.145."

19 "51 (11) - In this Act, 'medical aid' means  
20 the medical, surgical, dental, and optomet-  
21 rical aid, the aid of drugless practitioners  
22 registered under The Drugless Practitioners  
23 Act, the aid of chiropodists registered under  
24 The Chiropody Act, and hospital and skilled  
25 nursing services, and, where a workman is  
26 rendered helpless through permanent total  
27 disability, such other treatment, services  
28 or attendance and the artificial member  
29 or members and apparatus and repair above  
30 mentioned."





1 The brief then provides information relevant  
2 to the practice of optometry.

3 MR. ESTEY: I take it, Mr. Duffy, that the  
4 present administration of the Act by the Board under section  
5 51, in fact, recognizes and pays for optometric aid rendered  
6 by your membership?

7 MR. DUFFY: As at present.

8 MR. ESTEY: And you have no difficulties  
9 in your dealings with the Board, in your reportings to  
10 the Board?

11 MR. DUFFY: No.

12 MR. ESTEY: The procedure is acceptable  
13 to you?

14 MR. DUFFY: That is right.

15 MR. ESTEY: And those cases which are  
16 unusual and not covered by form 192, those are covered by  
17 special authority granted by the Board and I take it you  
18 dont have any trouble getting that authority when you  
19 need it?

20 MR. DUFFY: Quite right.

21 MR. ESTEY: So, as you have already said,  
22 the simple heart of your submission is that you would like  
23 to have in the Statute the right which, in fact, is granted  
24 to the injured workman.

25 MR. DUFFY: That is it.

26 MR. ESTEY: Thank you very much.

27 THE COMMISSIONER: Thank you very much.

28 MR. ESTEY: Do Mr. Lamont or Mr. Baker  
29 wish to say anything?

30 MR. LAMONT: Nothing further than that







1 THE COMMISSIONER: The inclusion, or other-  
2 wise, of these words would not affect your position one  
3 way or the other. It is simply a matter of regularizing  
4 something that already exists?

5 MR. DUFFY: That is correct. That is our  
6 submission.

7 THE COMMISSIONER: Thank you.

8 MR. ESTEY: Now, Mr. Commissioner, out of  
9 alphabetical order, at their request, we have the Ontario  
10 Chiropractic Association, whom I understand is now present.

11 MR. SUTHERLAND: Mr. Commissioner, my name  
12 is Donald C. Sutherland, Executive Secretary of the Ontario  
13 Chiropractic Association. With me this morning are two  
14 colleagues, James W. Ellison, practicing in Toronto, and  
15 Edward A. McDonough, who practiced in Elliot Lake in the  
16 mining community, some years ago. I feel they may be help-  
17 ful in answering questions which you may wish to put to us  
18 later.

19 1. Our delegation is appearing before this  
20 Commission as representatives of the Ontario Chiropractic  
21 Association, the provincial division of the Canadian  
22 Chiropractic Association, representing 75 per cent of the  
23 practicing chiropractors in the Province. We feel that  
24 the recommendations presented in this brief are construc-  
25 tive in nature and, if adopted, will be of great assistance  
26 in improving the health care provided to injured workers  
27 under the Workmen's Compensation Act. If, after reviewing  
28 our submission, you find a need for additional information,  
29 you may be assured of our fullest cooperation.

30 ECONOMIC FACTORS IN BACK INJURY CASES





1 2. The increasing incidence of spinal injuries  
2 in our industrial environment is a matter of concern and  
3 has been studied recently by the Department of Research  
4 and Statistics of the American Chiropractic Association.  
5 Using information obtained from the Department of Health,  
6 Education and Welfare of the United States Government, the  
7 United States Department of Labour, the National Safety  
8 Council, and the National Referral Centre for Science and  
9 Technology, a comprehensive report has been prepared which  
10 we submit as Exhibit 1.

11 3. The report will speak for itself so there  
12 is no need for us to quote extensively from it in this  
13 submission; however, we would like to point out, and to  
14 emphasize, that according to the Department of Health,  
15 Education and Welfare, Public Health Service, during the  
16 two year period from July, 1959 to June, 1961, 35.5 per  
17 cent of all back injuries took place while the victim was  
18 at work. Further, the impact upon the nation's economy  
19 is estimated by the National Safety Council to be four  
20 times the direct cost. Applying this figure to the United  
21 States, it is calculated that back injuries cost America  
22 one billion dollars annually. Applying it to the cost  
23 of back injuries reported by the Ontario Workmen's Compens-  
24 sation Board in 1963, we find that the Province's economy  
25 was damaged to the extent of \$25,600,000.00. (6,416,943  
26 x 4 - W.C.B. Annual Report, 1963, page 52.)

27 4. In 1963 the U.S. Department of Labour  
28 issued a report entitled "Federal Work Injury Facts". It  
29 analyzed the incidence of disabling, non-fatal, work  
30 injuries to civilian federal employees, by principal





1 anatomical location, for the years from 1952 to 1961. The  
2 report demonstrated that while the over-all rate for all  
3 kinds of non-fatal disabling injuries had increased by 5  
4 per cent, the rate for back injuries (excluding disc cases)  
5 rose by a whopping 24 per cent. We do not have a similar  
6 analysis for Ontario, but we do know from the report of the  
7 Ontario W.C.B. for 1963, that back and spine injuries in  
8 that year represented 19 per cent of all cases and 20.3  
9 per cent of total costs.

10 I might insert a comment here, Mr. Commis-  
11 sioner, that we have also located a report dated 1955 pre-  
12 pared by the Department of National Health and Welfare in  
13 Ottawa at which time they were seriously concerned about  
14 the increase in back injuries in industry, and the report  
15 points out that the ratio of back injuries is from 3 to  
16 16 per cent of all disabling injuries at that time.

17 TREATMENT PROBLEMS IN BACK INJURY CASES

18 5. The above figures serve to underline the  
19 important influence that spinal injury can exert upon the  
20 Province's economy, but they say nothing in regard to  
21 treatment methods. Very serious consideration should be  
22 given to the need for improving present methods of treat-  
23 ment for the purpose of returning the worker to his job  
24 as soon as possible and, at the same time, reducing time  
25 loss and production loss in industry.

26 6. An important step in this direction was  
27 taken by the Workmen's Compensation Board of Ontario a  
28 few years ago, when they conducted a study of low back  
29 pain in men receiving compensation. A report of this  
30 study was published in the July 9th, 1966, issue of the







1 Canadian Medical Association Journal and is attached to  
2 this brief as Appendix 1. Three short quotations from this  
3 report follow:

4 7. "The findings in this study raise doubt  
5 concerning the efficacy of conservative  
6 medical treatment in general for patients  
7 in the common 'problem low back' category,  
8 namely those in whom the diagnosis is  
9 herniated intervertebral disc or disc de-  
10 generation and strain, and who continue to  
11 be disabled longer than six weeks. Perhaps  
12 it would be wiser, in cases where there is  
13 no definite indication for surgical inter-  
14 vention, to recognize the inadequacy of  
15 our present methods of treatment and to  
16 search for a completely new approach."

17 8. "The efficacy of conservative medical  
18 treatment in these cases, as commonly  
19 carried on with the help of physical therapy,  
20 is questioned. 'The need for study, to  
21 improve or create new methods of management  
22 for these cases, is emphasized'."

23 9. "The failure of treatment in six of each  
24 ten cases indicates that present-day  
25 methods of management of such patients are  
26 unsatisfactory."

27 10. It is significant to note that the chiro-  
28 practic management of back injury cases was not included  
29 in this study. While we ~~were~~ disturbed by this at the time,  
30 in retrospect we should perhaps concede that it was probably





1 just as well to limit the first study to methods used at  
2 the Compensation Board Rehabilitation Centre.

3 EFFECTIVENESS OF CHIROPRACTIC CARE

4 11. Chiropractic care of sprain and strain  
5 injuries to the spinal column was the subject of a study  
6 conducted in Florida in 1956. First Research Corporation,  
7 a nationally recognized and independent research organiza-  
8 tion, microfilmed the records of 19,666 cases from the files  
9 of the Florida Industrial Commission. The report on this  
10 study is presented as Exhibit 2.

11 12. Sprain or strain injuries of this type are  
12 most commonly caused by trauma resulting from lifting,  
13 pushing, pulling or wielding of objects. The State of  
14 Tennessee reports that 75.7 per cent of back injuries are  
15 caused in this manner. This view is supported in the study  
16 carried out for the Workmen's Compensation Board of Ontario  
17 (Appendix I), in which the "mechanism of injury" is described  
18 as "Strains in flexion, rotation and with lifting", caus-  
19 ing 87.7 per cent of the injuries in the study.

20 13. The Florida survey (Exhibit 2) demonstrates  
21 that this type of injury, cared for under chiropractic  
22 management, responds in less time and at less expense than  
23 when under orthodox medical care. Some of the figures  
24 shown under the heading, "Significance of Major Findings"  
25 on page 5 and 6, are as follows:

26 Patients in the survey who were under  
27 chiropractic care were returned to their  
28 jobs in 1/3 of the time required by those  
29 under orthodox medical care. Costs of  
30 treatment under orthodox medical care,







administered by general practitioners, was 27.5 per cent more than costs of chiropractic care. In cases attended by medical specialists the costs were more than 200 per cent greater than chiropractic costs, yet under chiropractic care the patient was returned to work in an average of 2.5 days compared to 30 days under specialists' care.

14. The efficacy of chiropractic management in these back casds is further emphasized by Dr. Edgar Cyriax, graduate of the University of Edinburgh, now in the Department of Physical Medicine at St. Thomas' Hospital. Dr. Cyriax is quoted in the Lacrcix Royal Commission report recently released by the Government of Quebec:

"Based on my knowledge of several thousand cases, I have come to the following conclusions:

- a) Slight displacements of vertebral and pelvic bones occur very frequently, especially in cases of trauma (sudden knocks, etc.)
- b) A great many symptoms of diseases can easily be explained by such displacements.
- c) Most of these displacements can be reduced painlessly.
- d) Their adjustment is an essential element and even a sine qua non for healing or improving the pathological state caused by these displacements."

15. In another paragraph in which he discusses manipulation, Dr.Cyriax states:





1 "But most patients who need it never get it.  
2 How can these be so? It is a large hiatus  
3 costing the Health Service millions."

4 16. The value of chiropractic vertebral manipu-  
5 lation as a method of treatment was studied by The Honour-  
6 able Mr. Justice Gerard Lacroix in preparing his report on  
7 chiropractic for the Government of Quebec. The Hall Com-  
8 mission (Royal Commission on Health Services) agreed,  
9 (Exhibit 3, paragraph 5) after discussing the matter with  
10 Mr. Justice Gerard Lacroix, to accept his findings as having  
11 application across Canada. The most significant of these  
12 findings, in so far as this submission is concerned, is that  
13 chiropractic vertebral manipulation is a valuable system of  
14 treatment and should be available to people under provincial  
15 statute.

16 17. Under the Workmen's Compensation Act of  
17 Ontario, it has been provided to injured workers for many  
18 years, and its use has steadily increased. The worker has  
19 his initial choice of practitioner following injury but  
20 may not change to another practitioner without the Board's  
21 approval.

22 18. The statistics found in Exhibit 2 demonstrate  
23 the effectiveness of this therapy in cases of spinal injuries  
24 of the sprain and strain variety caused by lifting, pushing,  
25 pulling, etc. For emphasis, we repeat that in the survey  
26 of "problem low back" cases carried out by the Workmen's  
27 Compensation Board (Appendix I) at its Rehabilitation  
28 Centre, it is stated that 87.7 per cent of the cases in  
29 the survey were caused by "strains in flexion, rotation  
30 and with lifting". A natural area, therefore, for the





1 application of spinal adjustments by qualified chiropractors  
2 - yet this treatment was not included in the study.

3 19. Although the chiropractic management of  
4 spinal injuries is highly effective, there are always those  
5 cases which are found to require other types of care. When  
6 a patient fails to make satisfactory progress the Board will  
7 arrange for him to receive further examinations and to be  
8 transferred to medical treatment. To the best of our  
9 knowledge, the reverse of this procedure is not carried out.  
10 A patient who has failed to respond to medical care is  
11 rarely, if ever, given the benefits of treatment by a  
12 chiropractor.

13 20. The results that could be obtained through  
14 such a procedure are well known to medical specialists who  
15 have studied chiropractic vertebral manipulation. Dr.  
16 John McM. Mennell, of the Physical Medicine and Rehabilitation  
17 Service, Veterans Administration Centre, Los Angeles,  
18 California, states the facts very clearly in his book en-  
19 titled "Back Pain - Diagnosis and Treatment Using Manipu-  
20 lative Techniques" (Little, Brown and Company, 1960). On  
21 pages 3-5, he discusses the improved methods of handling  
22 back problems and makes the following statements:

23 21. "During the past 50 years there have been  
24 six major theories as to the cause of pain  
25 in the lower back. Methods of treatment  
26 have been devised for each one ..."

27 "None of these theories ever lived up to  
28 the claims made for them by their proponents,  
29 though there was some truth to a greater or  
30 lesser degree in each of them .







1 The public soon came to realize that they  
2 would find greater relief more quickly and  
3 more economically from osteopathic and  
4 chiropractic treatment of their backs than  
5 they would from orthodox medical treatment."

6 22. "Our profession has been rapidly losing  
7 ground to other groups who practice the  
8 healing arts in all problems concerning  
9 joint pain, but particularly in the field  
10 of back pain."

11 23. "Backache results in one of the greatest  
12 economic drains on the civilized world  
13 today, not only in money but in loss of  
14 productivity."

15 24. These words of Dr. Mennell summarize the  
16 problem very accurately and completely and reinforce the  
17 points which we have made so far in this submission; namely

18 a) the detrimental influence that back  
19 injuries exert upon the nation's economy.

20 (Exhibit 1)

21 b) the difficulties which "problem low  
22 back" cases present to the medical profes-  
23 sion and the unsatisfactory results obtained  
24 through orthodox medical treatment.

25 (Appendix I)

26 c) the important contribution that chiro-  
27 practors could make in the handling of  
28 these conditions. (Exhibit 2)

29 DURATION OF TREATMENT

30 25. A chiropractor treating a patient who is





1 on compensation must, at the end of 17 days, request per-  
2 mission from the Board to extend treatment beyond that  
3 time if he feels it is necessary. These extensions may be  
4 requested and obtained either over the telephone or by mail.  
5 Many years ago the time limit was 7 days with the added  
6 stipulation that a medical examination be obtained to deter-  
7 mine whether the treatment should be continued. This was  
8 subsequently revised to a period of 14 days without the  
9 need for a medical examination; however, the chiropractor  
10 was then required to contact the Board to request an exten-  
11 sion of treatment. A few months ago the period of time was  
12 again lengthened; this time to 17 days.

13               Mr. Commissioner, we have not yet been able  
14 to determine why it was extended by three days, just what  
15 the criteria was for that. However, at the moment, it is  
16 17 days.

17               Requests for extended time must still be  
18 made if treatment is necessary beyond the 17th day.

19 26.           We believe that this automatic requesting of  
20 an extension of time creates an undue administrative burden  
21 upon both the Board personnel and the chiropractor. If  
22 there is any delay in obtaining the authorization to con-  
23 tinue treatment, it could cause delay and confusion in the  
24 patient's treatment program. We feel that the routine  
25 report on the patient's condition and progress should enable  
26 the Board to assess the case without the need to telephone  
27 or write a letter automatically on the 17th day. The very  
28 fact that extensions are granted over the telephone demon-  
29 strates that the Board could exercise the same degree of  
30 control and supervision on the basis of progress reports







1 Nothing could be said over the telephone that could not  
2 be included in the routine report.

3 27. It is of interest to note here that, whereas  
4 a chiropractor must request an extension after only 17 days,  
5 the "problem low back" cases studied in the survey (Appendix  
6 I) were not considered as "problems" until they had been  
7 under the care of a private medical practitioner for six  
8 weeks. Considering the overwhelming evidence of the effi-  
9 cacy of chiropractic management of spinal injuries it would  
10 seem that this automatic 17-day limit, compared to six weeks  
11 under medical care is hardly justified.

12 28. In the report of the Commission of Inquiry  
13 into the Workmen's Compensation Act in British Columbia,  
14 1966, The Honourable Mr. Justice Charles W. Tysoe states  
15 on page 160:

16 "The Legislature has expressly recognized  
17 the right of qualified chiropractors to  
18 treat injured workmen, and in this respect  
19 has put them on the same plane as members  
20 of the medical profession, with their  
21 treatment subject to the same supervision  
22 and control by the Board."

23 29. We would point out here that there is no  
24 regulation in British Columbia requiring the chiropractor  
25 to ask for an extension after 17 days. The Board makes  
26 its decision on the basis of the reports submitted, as they  
27 do in cases under medical care. Of course, the Board in  
28 Ontario, as in British Columbia, has the right to call in  
29 a patient for examination at any time in the proper exer-  
30 cising of its responsibilities.





1 ROYAL COMMISSION FINDINGS

2 30. The conclusive evidence of the distinctive  
3 contribution that can be made by members of the chiropractic  
4 profession in the field of health services, has been supported  
5 by the findings of several Royal Commissions in recent years.  
6 These commissions are listed below for the information of  
7 this Inquiry, along with quotations or comments on their  
8 decisions:

9 31. Commission of Inquiry into the Workmen's Compensation Act  
10 of Ontario,

11 The Honourable Mr. Justice W.D. Roach, Commissioner  
12 1949-50

13 During this inquiry the Ontario Medical  
14 Association and the College of Physicians and Surgeons of  
15 Ontario requested that our services be removed as a benefit  
16 under the Act. The Commissioner rejected this proposal and  
17 stated on page 103 of his report:

18 "The Board is not concerned with any  
19 jealousies or conflict in opinion or  
20 technique that may exist between physicians  
21 and drugless practitioners. The welfare  
22 of the injured workman is its main concern."

23 32. Honourary Royal Commission Appointed to Inquire into  
24 the Provisions of the Natural Therapists Bill  
25 Western Australia, 1961

26 This Commission decided that the chiroprac-  
27 tors were providing a useful service that was in demand by  
28 the people of Western Australia and recommended that chiro-  
29 practic legislation be enacted by the Legislature and that  
30 a college be established in Australia. The legislation has





1 since been passed and a college is under consideration by  
2 the Australian chiropractors.

3 33. Royal Commission Inquiring into Chiropractic and

4 Osteopathy, for the Government of Quebec,

5 The Honourable Mr. Justice Gerard Lacrois, Commissioner

6 1963-65

7 This Commission's findings in relation to  
8 chiropractic treatment have been accepted by the Royal  
9 Commission on Health Services (Hall Commission). The  
10 Commission recognizes the value of chiropractic vertebral  
11 manipulation as a method of treatment and recommends that  
12 suitable legislation be established in Quebec. The Govern-  
13 ment introduced this legislation for first reading before  
14 the recent Quebec election.

15 34. The Commission also pointed out that it  
16 would be dangerous for those untrained in the procedure  
17 to attempt to apply it. The report states that generally  
18 speaking, physicians and physiotherapists are not trained  
19 in vertebral manipulation but that chiropractors, by virtue  
20 of their course of study in accredited colleges, are quali-  
21 fied in this field. Our analysis of the French version of  
22 this report is presented as Exhibit 3 (see paragraphs 30-  
23 35 in Exhibit 3). The English translation of the report  
24 is still being prepared by the Queen's Printer in Quebec  
25 City.

26 35. Commission of Inquiry into the Workmen's Compensation Act

27 in British Columbia

28 The Honourable Mr. Justice Charles W. Tysoe, Commissioner

29 1966

30 Once again representatives of organized







1 medicine requested that the services of chiropractors be  
2 deleted from the Act - a proposal rejected by Mr. Justice  
3 Roach in Ontario 16 years earlier. In this instance, Mr.  
4 Justice Tysoe took the same view as the Ontario Commissioner  
5 and rejected the recommendation. He went further and sug-  
6 gested in his report that posters printed by the Board  
7 should make it clear to workers that chiropractic treatment  
8 is available under the Act.

---

9 W.C.B. POSTERS IN ONTARIO

10 36. Posters issued by the Workmen's Compensation  
11 Board in Ontario have been a matter of concern to our pro-  
12 fession for about ten years. Until a few months ago the  
13 posters carried no explanation of the words "drugless  
14 practitioner", thereby leaving the worker in doubt as to  
15 the exact benefits available to him.

16 37. After many years of effort we were success-  
17 ful in convincing the Board that some clarification should  
18 be made. This was done by adding the words "chiropractor"  
19 and "osteopath" in brackets following "drugless practition-  
20 er". This is quite acceptable to us, except for the fact  
21 that the posters are not being distributed until a firm  
22 requests one to replace a worn poster presently on the  
23 bulletin board. We feel that it might take years to re-  
24 place all the posters in Ontario in this manner and wish,  
25 therefore, to recommend that all obsolete posters presentl  
26 on display be replaced by the new version which clarifies  
27 the benefits included under the Act. Until this is done  
28 we will continue to hear complaints that industrial nurses,  
29 first-aid attendants or personnel managers, are advising  
30 workers that they may not attend a chiropractor under





1 compensation. This has been a recurring problem for many  
2 years and can only be corrected by prompt distribution of  
3 the new posters.

#### 4 MILEAGE PAYMENTS

5 38. Respecting the allowances paid for mileage  
6 travelled while on house calls, we would like to draw the  
7 Commission's attention to a situation which we believe must  
8 be rectified.

9 39. At the present time, the Board pays at the  
10 rate of fifty cents per mile in one direction. However,  
11 "no mileage is paid for treatment in the district of other  
12 doctors" (Schedule of Chiropractic Fees - Item 6 - Exhibit  
13 4). This can only be interpreted to mean that the Board  
14 feels the patient could receive the same treatment from a  
15 physician. It would appear from this regulation that if  
16 a pediatrician or ophthalmologist has offices close to the  
17 patient's home, there will be no mileage paid to the chir-  
18 opractor who is called upon to travel some distance to  
19 reach the patient. While we recognize that there may be  
20 some need to regulate distances travelled on house calls,  
21 the present policy is not acceptable to our association

22 and we recommend that a more reasonable approach be adopted

23 We now come to our recommendations, Mr.  
24 Commissioner, which I will read and perhaps comment on as  
25 we proceed.

#### 26 RECOMMENDATIONS

27 40. 1) That the services of duly qualified,  
28 licenced chiropractors be added to the treatment methods  
29 presently available in the Compensation Board Rehabilita-  
30 tion Centre at Downsview, Ontario, and in view of the







1 difficulties experienced at the Centre in the handling of  
2 low back cases, that the full benefit of chiropractic know-  
3 ledge and clinical application be added to any problem low  
4 back clinics. We believe that in the specialized field of  
5 neurospinology, in which the chiropractor receives his  
6 training, it is a serious error of omission to withhold this  
7 method of therapy from injured workers.

8 I might comment, here, sir, that the chiropractic  
9 care is readily available to the man as an initial  
10 choice, but when he becomes a patient in the Rehabilitation  
11 Centre, he has no opportunity of making this choice and  
12 there is never, to our knowledge, any recommendation that  
13 this service is available to him, although it is available  
14 to him under law.

15 2) That patients having back problems which  
16 have not responded satisfactorily under medical treatment,  
17 be transferred to qualified chiropractors for treatment,  
18 just as patients under a chiropractor's care are presently  
19 transferred to a medical practitioner if progress has been  
20 unsatisfactory.

21 I will be referring later, to certain medical  
22 quotations which will refer to this recommendation.

23 3) That in view of the difficulties of  
24 adjudication experienced in the area of spinal injuries,  
25 and in view of the increasing use of chiropractors' services  
26 in this field, and particularly in view of the benefits  
27 which would result from the broader use of these services,  
28 a chiropractor be retained as a consultant by the Board.  
29 In the event that recommendations 1) and 2) are accepted  
30 by the Commission, then the post of chiropractic consultant





1 would appear to be essential.

2 I might comment here, sir, that it might  
3 also be helpful in establishing a working relationship  
4 between the medical and chiropractic professions at a Board  
5 level which has been difficult to establish.

6 4) That the limit of 17 days on chiropractic  
7 treatment before requesting an extension from the Board, be  
8 discontinued, and decisions based on progress reports.

9 5) That in cases where the Board deems it  
10 advisable to transfer the patient for a different method  
11 of treatment, there should be no lengthy period during which  
12 the patient is not receiving help from anyone. The first  
13 visit to the second practitioner should be within one week  
14 of the final visit to the first practitioner. Some patients  
15 have had to wait for much longer periods of time without  
16 treatment of any kind.

17 6) That mileage payments of \$1.00 per mile  
18 be met by the Board provided there is no other chiropractor  
19 in the patient's community.

20 I might comment here, that I feel the important  
21 part of this recommendation is the second part, "pro-  
22 vided there is no other chiropractor in the patient's com-  
23 munity". We prefer this to the present policy that mileage  
24 would not be paid if there is any doctor in the patient's  
25 community.

26 7) That the up-to-date posters (Form 82),  
27 authorized and printed by the Board, be distributed to firms  
28 in Ontario without further delay in order that workers and  
29 first-aid attendants may clearly understand the treatment  
30 benefits provided under the Act. As mentioned earlier,





1 the Royal Commission on the Workmen's Compensation Act in  
2 British Columbia (1966) recommended that Board posters  
3 should clarify for the workers the treatment benefits pro-  
4 vided. Our Ontario posters were revised many months ago  
5 but will not succeed in solving this problem until they  
6 have been distributed.

7 CONCLUSION

8 41. We trust that these recommendations will be  
9 helpful to this Commission. The obvious need for finding  
10 new methods for treating back injury cases, as stated in  
11 the survey of "problem low back" cases (Appendix I), serves  
12 to emphasize the importance that should be attached to this  
13 situation. We wish to assure this Commission, and the  
14 Board, of our fullest cooperation in these matters and of  
15 our interest in making a distinctive contribution to the  
16 treatment program provided for injured workers in Ontario.

17 42. In the light of certain submissions which  
18 have been made to similar Commissions in the past, both  
19 in Ontario and British Columbia, we would respectfully  
20 request the privilege of studying any presentations which  
21 make references to our profession or to our methods of  
22 treatment, and of commenting thereupon if deemed advisable  
23 by our delegates.

24 Submitted on behalf of the Ontario  
25 Chiropractic Association.

26 Mr. Commissioner, we also have some comments  
27 to make in regard to a recommendation made by the Ontario  
28 Medical Association. Do you wish us to proceed with that?

29 THE COMMISSIONER: In connection with the  
30 last of your Conclusion, I interpret that to mean that







1 should further evidence be brought forward here, that would  
2 call for a reply from you, you would be permitted to give  
3 it, is that what you are talking about?

4 MR. SUTHERLAND: I think probably this  
5 has been solved because we have a copy of the briefs we  
6 were concerned about. I doubt that this would be a problem.

7 THE COMMISSIONER: In any event, if that  
8 situation occurs in regard to anybody making submissions  
9 to this Inquiry, they will be heard.

10 MR. SUTHERLAND: Fine, thank you.

11 We come now to comment on the brief submitted  
12 by the Ontario Medical Association this morning. On page  
13 8 it is recommended that "requests for additional privileges  
14 or recognition be refused as it is our considered opinion  
15 that drugless practitioners registered under these Acts do  
16 not possess sufficient medical knowledge to enable them to  
17 make a complete assessment of an injured workman".

18 This question was also raised by our medical  
19 friends in British Columbia during the Royal Commission of  
20 Inquiry into the B.C. Compensation Act. The question was  
21 asked of Dr. Davidson, who was on the stand representing  
22 the Compensation Board of British Columbia. Dr. Davidson  
23 answered the question and I would like at this time to  
24 read into the record, his answer. He was asked if chiro-  
25 practors had the ability to fill out the examination form  
26 and to assess the man's condition. His answer:

27 "My only answer to that, Dr. Walsh, would  
28 be that I have seen chiropractic forms  
29 that do give us information and even  
30 diagnosis and some findings, which in your





1 particular case indicate that the man has a  
2 disc and they so state. Now where they  
3 learn, where they got their ability to make  
4 this diagnosis isn't for me to say, but  
5 they do so state and I must admit that in  
6 the long run, they have been proven right.  
7 Now, on the other hand I have seen medical  
8 reports submitted that give us nothing  
9 except the history, such as 'This man bent  
10 down'. The physical examination says,  
11 'Protruded intravertab~~ral~~ disc', and that  
12 is all that is on the medical form which  
13 is of less value to us than the chiropractic  
14 form, if you want my honest opinion."

15 Further, on the matter of our members'  
16 ability to assess a man's condition, I would like to read  
17 into the record certain paragraphs from three letters  
18 received from Safety Engineers in Elliott Lake during the  
19 time<sup>of</sup>/Edward McDonough's practice in that community. I  
20 wont read the whole letter but we will file these with  
21 the Commission, if you wish, sir. The first letter is  
22 signed by a safety instructor and states:

23 "The Safety Department of this mine has  
24 benefited from the guidance you have given  
25 us . . ."

26 These letters are dated 1960.

27 "The Safety Department of this mine has  
28 benefited from the guidance you have given  
29 us on innumerable occasions, such as cases  
30 which have shown chronic disorders or







*Nethercut & Young*

*Toronto, Ontario*

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maldevelopments. Your reports to us enable us to place these men in less dangerous jobs, thereby assisting the men and ourselves.

Where low back injuries have been sent to you for treatment the patient has been able to return to full duty in a very short time, our statistics prove this point where lost time is concerned.

On your departure we shall miss your services, low back injuries will revert to the old procedure, several weeks spent lying in hospital, to be eventually discharged in many cases as a semi-fit person with a return to work slip stating Full Duty, no advice, no guidance and a reoccurring back injury at some later date.

We sincerely hope that in the very near future, the industry, W.C.B. and many gentlemen of the medical profession will realize the importance of your work."

This is on a letterhead of Algom Uranium Mines Limited.

The Milliken Lake Uranium Mines Limited,  
signed by a safety engineer:

"It is with regret that we learn of the impending closure of your Chiropractic Clinic.

During the two years of operation of this Company, with an average payroll of between 800 and 900, it has become standard





1 to have all claims for industrial injury  
2 involving strains or sprains of the neck,  
3 shoulders, back and hips referred to your  
4 Clinic for examination.

5 We have had confidence in your opinions,  
6 and feel that this practice was beneficial  
7 to both the employee and to ourselves. We  
8 have at no time ever regretted this practice  
9 and will certainly miss your services."

10 Stanleigh Uranium Mining Corporation Limited,  
11 signed by a safety director:

12 "We understand that the services of your  
13 office may cease to be available in the  
14 near future.

15 Before this happens we would like you to  
16 know that the services rendered to this  
17 Company in the treatment of back injuries  
18 have been most gratifying.

19 There is no doubt in our minds that the  
20 prompt application of chiropractic treatment  
21 has greatly lessened the number of days  
22 previously lost due to this type of injury.

23 May we extend our sincere thanks..."  
24 and the rest is just a personal comment. Do you wish that  
25 we should file these letters, Mr. Commissioner?

26 THE COMMISSIONER: If you please.

27 EXHIBIT NO. 20

28 Three letters to Elliot Lake  
29 Chiropractic Clinic from Safety  
30 Engineers of Algom Uranium Mines





Limited, Milliken Lake Uranium  
Mines Limited and Stanleigh Uranium Mining Corporation Limited,  
dated 1960.

THE COMMISSIONER: All of that refers to treatment that was paid for by the Board, I suppose.

MR. SUTHERLAND: The bulk of this practitioner's practice was Compensation work, yes sir.

I might point out that these letters tie in very closely with our Exhibits which indicate the successful handling of chiropractic cases in Florida in a study of 20,000 cases of the Florida Industrial Commission and it certainly indicates that the chiropractor is quite capable in the matter of assessing the man's injury and the type of treatment that should be provided for him.

I might point out also that our members do refer patients to medical practitioners when they feel it necessary and we are presently involved in a cross-Canada study to substantiate that this is happening on a very large scale, that our men are cooperating with other professions in the health field.

We find it almost incomprehensible that, in view of the documented shortages of health care personnel - and we don't need to go into this in detail, I am sure everyone realizes that this is the case - we find it ...

THE COMMISSIONER: Of what personnel?

MR. SUTHERLAND: I think all personnel have declared shortages, from physicians, nurses --

THE COMMISSIONER: You said "health care",







1 MR. SUTHERLAND: I was referring to all  
2 health care personnel. We find it very difficult to under-  
3 stand why the medical profession would take the view that  
4 the beneficial services of other groups in the health field  
5 should not be provided under the Workmen's Compensation  
6 Act on as broad a basis as is possible.

7 There is no longer a question about the  
8 value of chiropractic vertebral manipulation. Royal Com-  
9 missions have established this and I shall be quoting  
10 medical authorities who agree with these Commissions. So  
11 we feel that the matter of assessment is not an issue .

12 I would like to quote, then, from Dr. W.B.  
13 Parsons of Red Deer, Alberta, who addressed the Canadian  
14 Medical Association Convention in Banff on June, 1960 on  
15 spinal manipulation and as written in the C.M.A. Journal  
16 on the subject. In the Journal for July 15th, 1958, Dr.  
17 Parsons writes as follows:

18 "The reason we took up manipulation was an  
19 interest in backache, with the early dis-  
20 covery that many patients who failed to  
21 respond to routine medical treatment went  
22 to a manipulator and received immediate  
23 relief."

24 Dr. J.M. Mennell of the Physical Medicine  
25 and Rehabilitation Service of Veterans' Administration  
26 Centre, Los Angeles, is recognized as one of the few  
27 medical authorities on spinal manipulation, and has made  
28 the following statements in his book, "Back Pain" published  
29 in 1960. I would like to quote two or three paragraphs  
30 from pages 4 and 5. Page 4:





1 "The public soon came to realize that they  
2 would find greater relief more quickly and  
3 more economically from osteopathic and  
4 chiropractic treatment of their backs than  
5 they would from orthodox medical treat-  
6 ment."

7 Page 5. I guess this has been inserted in our brief later:

8 "Our profession has been rapidly losing  
9 ground to other groups who practise the  
10 healing arts in all problems concerning  
11 joint pain, but particularly in the field  
12 of back pain. Backache results in one of  
13 the greatest economic drains on the civil-  
14 ized world to-day, not only in money but  
15 in loss of productivity."

16 On pages 11 and 13, Dr. Mennell writes as follows:

17 "The fascination in dealing with back  
18 problems is a never ending source of  
19 pleasure mingled with anxiety and should  
20 be most attractive to both the undergraduate  
21 and postgraduate student. Yet in medical  
22 schools and resident training programs  
23 students look askance at anyone who is  
24 attracted by these problems and with horror  
25 when they are faced with such problems  
26 themselves. This reaction is only because  
27 they are exposed to no teaching on the  
28 subject. They are offered no method of  
29 clinical examination by which they can assess  
30 the problem and they are not exposed to any







1 useful method of treatment which can ever  
2 positively be said to cure these patients  
3 except perhaps a spinal fusion which they  
4 are unable to follow to its successful con-  
5 clusion,unfortunately, perhaps because their  
6 curriculum passes them through orthopaedics  
7 too quickly,"

8 On page 13:

9 "It is because of the basic lack of teaching  
10 that the basic lack of understanding of  
11 back pain pervades our profession and be-  
12 cause empirical treatment is prescribed with-  
13 out pathological diagnosis the public more  
14 and more take their back problems away from  
15 the medical practitioners to those in other  
16 fields."

17 Under these circumstances we feel it is  
18 obvious why the assessment of a patient's spinal problem  
19 has presented difficulties to our friends in the medical  
20 profession. Some of these problems have been described  
21 by those writing in the C.M.A. Journal and by physicians  
22 lecturing to medical groups. Some of these men are Mennell,  
23 Lehmann, Barber and there are others, and they have been  
24 warning the medical profession through courses which have  
25 been held recently that medical practitioners are at times  
26 diagnosing organic complaints and they have listed the  
27 heart, gall-bladder and other organs as being involved.  
28 They have diagnosed organic complaints incorrectly because  
29 they have failed to recognize the importance of referred  
30 pain from the spinal column. The spine can produce pain





1 which will simulate the pain caused by certain organic con-  
2 ditions and speaking to the Toronto Academy of Medicine,  
3 recently Dr. Barbor from England, who is President of the  
4 British Association of Manipulative Medicine, told the  
5 members of the Academy that medicine had been guilty of  
6 errors in diagnosis which have caused people to believe  
7 that almost any condition can be corrected by manipulation  
8 because the patient subsequently consults either an osteo-  
9 path or a chiropractor and has his symptoms relieved.

10 A Toronto specialist addressing the College  
11 of General Practice of Toronto, Ontario Chapter in 1964  
12 was quoted by the Toronto press as saying:

13 "Pain referred from neck muscles to the  
14 chest may even be diagnosed as angina so  
15 that the patient goes in fear of his life  
16 and becomes ill from the stress of his  
17 fears. Such a man may then go to a manipu-  
18 lator and be cured."

19 Many more examples could be quoted to indi-  
20 cate the successful assessment and treatment of patients  
21 by chiropractors, after medical assessment and treatment  
22 had proved ineffective. However, these will serve to out-  
23 line the problem to the Commission and if further informa-  
24 tion is required, we shall be pleased to go into the matter  
25 in greater detail. We must, at this time, express our  
26 opposition to the recommendation made by the Ontario Medical  
27 Association when they suggest that any additional privileges  
28 or recognition be refused. The medical report, appendix I,  
29 emphasises strongly the need for new and improved methods  
30 of treating spinal conditions. Our Exhibit 2 demonstrates





1 the effectiveness of chiropractic treatment in such back  
2 injury cases.

3 Under these circumstances we feel that the  
4 only reasonable course of action is to provide the injured  
5 worker with the benefits of treatment by licenced chiroprac-  
6 tors on a broader basis than at present, such as suggested  
7 in our recommendations.

8 In conclusion, Mr. Commissioner, we wish to  
9 make one additional point in regard to the standard of  
10 manipulative practice. In 1964 our Association expressed  
11 concern over short courses being held to, in the words of  
12 The Canadian Medical Association Journal, to eliminate the  
13 ignorance which leads to prejudice in the mind of the  
14 physician toward manipulative procedures. These short  
15 courses are designed to acquaint the practitioner with the  
16 value of the therapy this would be fine, but if they are  
17 designed, as some of them are, as crash programs to attempt  
18 to teach the physician how to manipulate the spine in any-  
19 thing from one hour to five days, this is entirely inadequ-  
20 ate and we wish to deal with this by quoting a number of  
21 passages.

22 To come directly to the point, we quote from  
23 the report of the Lacrois Commission on Chiropractic,  
24 English edition, page 152:

25 "A doctor wishing to use manipulative  
26 treatment without having received thorough  
27 specialized training would commit as danger-  
28 ous and inadmissible an act as a chiropractor  
29 who might attempt surgery without receiving  
30 the appropriate medical training."







1 Page 73:

2 "The physician who has received a complete  
3 medical training and has practiced his  
4 profession regularly, cannot, in our humble  
5 opinion, use manipulative therapy without  
6 grave danger unless he has received long  
7 and careful specialized training in the  
8 use of this manipulative method and treat-  
9 ment."

10 Page 75:

11 "The preponderance of the evidence received  
12 indicates definitely that the teaching of  
13 this technique is not part of the medical  
14 curriculum and we believe that chiropractors  
15 who have taken a long course in an accredited  
16 school, may have received instruction and  
17 training giving them a sounder preparation  
18 for the administration of this spinal thera-  
19 peutic method than the physician who, in  
20 spite of his medical studies, has not been  
21 taught."

22 Page 76:

23 "Only specialists in the treatment of the  
24 spinal column by manipulation and trained  
25 in this manual technique, should use this  
26 method and chiropractors, in accordance  
27 with the present standards of their clini-  
28 cal instruction, in an accredited school,  
29 do receive an adequate training for this  
30 purpose."





1 Our concern arised out of the fact that medi-  
2 cal doctors are beginning to attempt manipulative therapy  
3 when they have received no formal training in it. Courses  
4 have been held which vary in length from one hour to five  
5 days but all hopelessly inadequate from the standpoint of  
6 training a person in the delicate art of spinal manipula-  
7 tion.

8 Mennell states it takes six months for an  
9 already qualified physician to become proficient in diag-  
10 nosis and therapy using spinal manipulation (page 110 of  
11 his book). Chiropractors are trained in the techniques  
12 during the entire four years of their course.

13 Mennell states on page 6, at the bottom of  
14 the page -- and this is a book on manipulation explaining  
15 the techniques that he has developed:

16 "It is with a feeling of some urgency, then,  
17 that this work which, for many, will be new,  
18 is now being presented. It is also with a  
19 sense of frustration that this work is offer-  
20 ed as manipulation whether used diagnostic-  
21 ally therapudically is an art which is dif-  
22 ficult to learn from the word and the printed  
23 illustration. It would be a pity if this  
24 presentation of the use of manipulative  
25 techniques, in the diagnosis and treatment  
26 of back pain were to produce a wave of over-  
27 enthusiastic clinical experimentation. The  
28 injudicious or impetuous use of manipula-  
29 tion can only result in failure or even  
30 harm. Then it is only human nature to blame







1 the procedure rather than the processor,  
2 who uses it ineptly."

3 As I have mentioned, Mennell, on another  
4 page states it would take at least six months for an already  
5 qualified physician to become proficient. We are gravely  
6 concerned, and we have stated in the public press two years  
7 ago this fact, that physicians who have taken anywhere from  
8 a one hour to a five day course in manipulation are attempt-  
9 ing these procedures on patients. Some of our members  
10 have had patients come to their offices after having been  
11 manipulated by a physician and have stated that if we had  
12 known this was the treatment we required, we would have  
13 come to you in the first place, because of your qualifica-  
14 tions.

15 In view of this problem, sir, we wish to  
16 add one recommendation to those already included in our  
17 brief. This will be recommendation number 8.

18 We recommend that since spinal manipulation  
19 forms no part of the medical curriculum and  
20 since ...

21 THE COMMISSIONER: That is the medical  
22 student curriculum?

23 MR. SUTHERLAND: Yes, sir.

24 And since the so-called courses being held  
25 for general practitioners are recognized  
26 as being inadequate, that the Workmen's  
27 Compensation Board only recognize spinal  
28 manipulation as a therapy for injured  
29 workers when it is administered by a  
30 chiropractor registered with the Board of





1 Directors of Chiropractice of Ontario, in  
2 order to maintain a high standard of manipu-  
3 lative spinal therapy.

4 I should comment to this extent, that we  
5 have not included the osteopathic profession here for no  
6 reason except that we felt we could not speak on their  
7 behalf. We certainly agree that the osteopaths, in our  
8 opinion, should be included in this recommendation but we  
9 felt they should speak to this themselves.

10 THE COMMISSIONER: May I look at Dr.  
11 Mennel's book for a moment?

12 MR. SUTHERLAND: Yes. My final comment,  
13 then, is to advise the Commission that in the State of  
14 Washington, the Medical Act at the present time prohibits  
15 physicians from practicing as chiropractors.

16 This is the conclusion of our submission,  
17 Mr. Commissioner, and if there are any questions, my coll-  
18 eagues and I will be pleased to answer them.

19 MR. ESTEY: First of all, I see in your  
20 brief that you represent 75 per cent of the practicing  
21 chiropractors in the province. How many practicing chiro-  
22 practors are there in Ontario?

23 MR. SUTHERLAND: Between 450 and 500 in  
24 active practice. Our membership is better than 350.

25 MR. ESTEY: And the practioners are licenc-  
26 ed in Ontario under the Drugless Practioners Act?

27 MR. SUTHERLAND: Yes.

28 MR. ESTEY: You mentioned at the very end  
29 of your eighth recommendation, "registered with Chiropractic  
30 of Ontario". What is that?





1 MR. SUTHERLAND: The licencing Board under  
2 the Drugless Practioners Act is called The Board of Directors  
3 of Chiropactic of Ontario.

4 MR. ESTEY: That is the provincially estab-  
5 lished Board under that statute?

6 MR. SUTHERLAND: The Government Licencing  
7 Board, yes.

8 MR. ESTEY: You will appreciate that we are  
9 not sitting as Mr. Justice Lacroix and decidding on what is  
10 and what is not treatment, but some of the things you have  
11 said relates to one of the problems we have and I would  
12 like to examine it in that light without getting back into  
13 the scientific theory. I take it that your practitioners  
14 are trained in Ontario at the Ontario College of Chiroprac-  
15 tic.

16 MR. SUTHERLAND: Yes, The Canadian Memorial  
17 Chiropactic College. There are also graduates from America.

18 MR. ESTEY: Do you have some coming in from  
19 outside?

20 MR. SUTHERLAND: Yes.

21 MR. ESTEY: From American colleges?

22 MR. SUTHERLAND: Yes.

23 MR. ESTEY: How long is the course?

24 MR. SUTHERLAND: Four years for nine months  
25 of each year which is equivalent to about five years of the  
26 university course.

27 MR. ESTEY: And after that, is it the  
28 status that relates to articleship in the law business or  
29 intership in medical training?

30 MR. SUTHERLAND: There is an internship







1 program following the medical hours of the latter two and  
2 a half years of the course. It does not interfere with the  
3 lecture hours.

4 MR. ESTEY: It is during the last two years  
5 rather than at the end of the course?

6 MR. SUTHERLAND: Yes.

7 MR. ESTEY: What is that -- internship  
8 or an institution type of thing?

9 MR. SUTHERLAND: It is in the Chiropractic  
10 College building.

11 MR. ESTEY: After that they write exams  
12 and they are licenced provincially?

13 MR. SUTHERLAND: Yes, and recently in 1963,  
14 our Canadian Association, with the aid of the University  
15 of Saskatchewan, established a National Examining Board  
16 which has since then been accepted by all of the provincial  
17 government examining boards across Canada so that our  
18 graduates now all write this national examination which  
19 qualifies them then to apply for a licence in any of the  
20 provinces.

21 MR. ESTEY: Under the Workmen's Compensa-  
22 tion Acts of other provinces, is the status of the chiro-  
23 practor materially different than it is in Ontario?

24 MR. SUTHERLAND: There certainly are some  
25 differences. As I mentioned, I don't think in any of the  
26 provinces is there a restriction of 14 or 17 days. I  
27 believe there was a restriction of a month in one of the  
28 other provinces but I can't be too specific about that.

29 MR. ESTEY: That is the restriction on  
30 the length of time for treatment?





1 MR. SUTHERLAND: Yes, that is right.

2 MR. ESTEY: Other than that, is there any  
3 difference in status as amongst the provinces. Perhaps we  
4 could deal with it more specifically: In Quebec, following  
5 the Lacroix Commission, was there any change in status under  
6 the Workmen's Compensation Act?

7 MR. SUTHERLAND: I mentioned all of the  
8 government licencing boards: There are two or three pro-  
9 vinces that don't have licencing boards. Quebec is one.  
10 There is no legislation in effect in Quebec, although it was  
11 recommended by the Lacroix Commission.

12 MR. ESTEY: You mentioned that in your  
13 report, but what does the Quebec Workmen's Compensation  
14 Board do, if anything, about your profession?

15 MR. SUTHERLAND: Because of the lack of  
16 legislative control, we are not included under the Compen-  
17 sation Act in Quebec.

18 MR. ESTEY: You are not now included in  
19 Quebec?

20 MR. SUTHERLAND: No.

21 MR. ESTEY: Are there any other provinces  
22 in which you are not now included in the Workmen's Compen-  
23 sation Act or administration?

24 MR. SUTHERLAND: Yes, in Nova Scotia.

25 MR. ESTEY: Any more?

26 MR. SUTHERLAND: Yes, the provinces of  
27 Prince Edward Island and Newfoundland have no chiropractic  
28 legislation.

29 MR. ESTEY: Therefore, you are not under  
30 their Compensation statutes either?







1 MR. SUTHERLAND: That is right. The Compen-  
2 sation Acts that include the service are British Columbia,  
3 Alberta, Saskatchewan, Manitoba, Ontario and New Brunswick.

4 MR. ESTEY: Everything from Ontario west  
5 plus New Brunswick?

6 MR. SUTHERLAND: You can say coast-to-coast  
7 if you will admit that New Brunswick is on the coast. That  
8 is a better way of putting it.

9 MR. ESTEY: You mentioned something which  
10 I would like to discuss before I get into the details of  
11 your brief. Your relationship with the Osteopathic profes-  
12 sion: What is the difference, if any, between the two  
13 professions, and their treatment?

14 MR. SUTHERLAND: I think from a manipulative  
15 standpoint there is very little difference except that the  
16 two professions develop independently and they may have  
17 certain characteristics about their manipulation which are  
18 unique to them, but I think probably one is as effective as  
19 the other. In the United States the osteopaths and their  
20 colleges have added education in the fields of surgery and  
21 pharmacology so that they are qualified in the practice of  
22 medicine. This is the reason that their course is a little  
23 longer than ours because they do study these subjects and  
24 we don't. However, in Canada they do not practice in this  
25 manner. I think in all provinces, they are limited to  
26 manipulative therapy. It is our desire to maintain our  
27 specialty in the manipulative field and not to become in-  
28 volved in fields which are already covered by medical  
29 practice.

30 MR. ESTEY: So that in summary, from a





1 layman's viewpoint, such as myself, it is fair to say that  
2 in the Province of Ontario the practice of an osteopath and  
3 that of a chiropractor, so far as the spinal injuries are  
4 concerned, is about the same?

5 MR. SUTHERLAND: I would say, yes. Perhaps  
6 our friend from the osteopathic profession would like to  
7 comment on it but that is my opinion.

8 MR. ESTEY: We have heard a great deal in  
9 this Commission about these back injuries and of how  
10 significant they have become in dollars and percentage of  
11 injuries and I see in your brief you quote some statistics  
12 which indicate that the rate of back injures has increased  
13 apparently five times the increase of injuries generally.  
14 And then back on page one, they are not numbered but it is  
15 the first page in your paragraph 3 --

16 MR. SUTHERLAND: We numbered the paragraphs  
17 and forgot the pages, I am sorry.

18 MR. ESTEY: You refer to 35.5 per cent of  
19 back injuries took place while the victim was at work.  
20 Do you have from your chiropractic practice - I take it  
21 you are a practitioner.

22 MR. SUTHERLAND: I am not in private  
23 practice any longer, although I was for ten years.

24 MR. ESTEY: Is there any explanation given  
25 by your profession as to the rising incidence of back  
26 injury?

27 MR. SUTHERLAND: We have not considered  
28 this in any formal manner but we do have a notion that  
29 it might very well be related to the gradual decrease in  
30 physical fitness in North America. At first thought perhaps





1 this sounds like an easy answer but seriously, tests of  
2 physical fitness held in North America have shown that, I  
3 think it is 57 or 58 per cent failed and on the same tests  
4 carried out in Europe, 7 or 8 per cent failed.

5 Now, a man who uses a power mower and drives  
6 to work and sits down to watch television and then goes to  
7 work and is called upon to lift 50 pounds and he hasn't  
8 done it for some time, I feel that the general level of  
9 physical fitness may have a great deal to do with the  
10 increasing incidence of back injuries. I grant you there  
11 are also a few people who will take advantage of a situa-  
12 tion. We don't feel there are very many of these, although  
13 it does exist, but I would think physical fitness is a  
14 big factor.

15 MR. ESTEY: Is the treatment of a back  
16 injury what you would call a predominant part of the prac-  
17 tice of a chiropractor or is it substantially his practice?

18 MR. SUTHERLAND: I think we could say that  
19 almost all of chiropractic practice is applied to the  
20 spine in one area or another. The neck region and the  
21 lower or lumbar spine are the most common areas involved  
22 and this would take up a very great percentage of chiro-  
23 practic practice.

24 THE COMMISSIONER: There must be a great  
25 deal of organic troubles. I understand you to say that  
26 the osteopaths cover pharmacology and surgery?

27 MR. SUTHERLAND: Yes, sir.

28 THE COMMISSIONER: And that you restrict  
29 yourselves to other work but there must be all sorts of  
30 organic troubles that come to you as well, are there not,







1 in connection with the internal organs?

2 MR. SUTHERLAND: If a patient consults us  
3 for a frank organic problem, which we feel is a pathological  
4 condition which may require medication or surgery, he would  
5 be referred for proper care. If we feel it is a functional  
6 disorder which is caused by nerve root irritation, we would  
7 treat the spinal problem as it presented itself but there  
8 is a definite referral of patients.

9 THE COMMISSIONER: For instance, an ulcera-  
10 tion in the intestinal tract, somewhere, what would that  
11 be considered?

12 MR. SUTHERLAND: It has been established  
13 by medical authorities - Dr. Parsons wrote on this subject -

14 MR. ESTEY: Is that the Red Deer man?

15 MR. SUTHERLAND: Yes, in the College of  
16 General Practice, in which he stated that medicine up to now  
17 has not understood the results obtained by manipulative  
18 therapy but that in recent years they have learned that,  
19 (this may become a bit **technical**) but they have discovered  
20 that the sympathetic nervous system which controls the  
21 circulation can be disturbed by spinal problems and Parsons,  
22 in his article states that the symptoms of deafness, blurring  
23 of vision, ringing in the ears and he lists some others,  
24 can be caused by spinal misalignment.

25 Taking this to the intestinal tract, if the  
26 circulation to the intestinal tract is affected by a spinal  
27 problem - and Parsons says that circulation can be affected -  
28 then the **resistance** of the digestive tract could be reduced  
29 enough that ulceration would occur. A patient with this  
30 problem may respond to spinal therapy or he may require





1 medical or surgical treatment depending on the seriousness  
2 of the condition and how far it has progressed. If it is  
3 in its initial stages, perhaps spinal therapy might be  
4 sufficient. If it isn't it would require other types of  
5 care.

6 MR. ESTEY: I take it from your answer  
7 that it happens as a regular feature in your practice, your  
8 profession's practice, that medical matters are referred  
9 by the chiropractor to the medical practitioners?

10 MR. SUTHERLAND: Yes, sir.

11 MR. ESTEY: I take it one of your main  
12 submissions here is that <sup>in</sup> the workings of the Workmen's  
13 Compensation Act there is no reciprocity?

14 MR. SUTHERLAND: That is correct.

15 MR. ESTEY: I take it, in connection with  
16 one of your requests that you want to bring about this  
17 reciprocity by having a voice in the administration of the  
18 medical side of the Workmen's Compensation Board and it is  
19 your proposal that there be a consultant?

20 MR. SUTHERLAND: Yes.

21 MR. ESTEY: In British Columbia, for example,  
22 you mentioned this matter was investigated. Is there a  
23 consultant available to the Board?

24 MR. SUTHERLAND: No, there is not, sir.  
25 The only reason for recommending that was because of our  
26 earlier recommendation that this type of treatment would  
27 be very helpful in the Downsview Rehab Centre and we felt  
28 if this therapy was to be added to the treatment available  
29 in the centre that there would be need for a consultant or  
30 an advisor of some kind to the Board. We presently have







1 one of our own members who does this on a voluntary basis.  
2 He visits the Board's offices on a regular routine and deals  
3 with any problems that occur but this is quite voluntary.

4 THE COMMISSIONER: What do you mean by that,  
5 voluntary?

6 MR. SUTHERLAND: Well, the Board doesn't  
7 pay any expense for this service. He is one of our com-  
8 mittee members and we pay his expenses.

9 MR. ESTEY: Is this out at the Rehabilita-  
10 tion Centre you are speaking of?

11 MR. SUTHERLAND: No, while he goes to the  
12 Board's offices.

13 MR. ESTEY: From what you said earlier I  
14 took it that on occasion you have a situation where one of  
15 your patients, one of a chiropractor's patients in taking  
16 treatment as a result of injury, is finally admitted to  
17 the Rehabilitation Centre and when he gets there there is  
18 no chiropractor and therefore his treatment is either dis-  
19 continued or changed to something other than chiropractic,  
20 is that correct?

21 MR. SUTHERLAND: Well, it means so much  
22 chiropractic - not so many chiropractic patients being  
23 admitted as medical patients. Perhaps if a chiropractic  
24 patient is admitted to the Centre perhaps there is a  
25 reason, perhaps he need orthopaedic care but if a patient  
26 who had been under medical care is admitted to the centre,  
27 we feel that he should have the benefit of chiropractic  
28 care which he has not had up to that time.

29 MR. ESTEY: Do you have any cases of the  
30 type I describe where the man has had chiropractic treatment





1 and ends up in the Rehabilitation Centre and has to either  
2 discontinue or switch to other types of treatment, does  
3 that happen?

4 MR. SUTHERLAND: I don't know, sir.

5 MR. ELLISON: I would think that there are  
6 cases which have been treated by a chiropractor that have  
7 to go to a rehab centre but usually in those cases they  
8 need surgery.

9 MR. ESTEY: Following that line up, what  
10 happens, does the chiropractor say that the man now needs  
11 surgery? I don't follow that.

12 MR. ELLISON: I can recall one or two cases  
13 where chiropractic care was not adequate to correct a con-  
14 dition. The man was referred to an orthopaedic specialist  
15 who then either sent him to the Rehab Centre or did spinal  
16 surgery, fusion.

17 MR. ESTEY: This is an illustration of what  
18 has been discussed here a moment ago that there is this  
19 liaison between the chiropractor and the doctor and in  
20 cases where the chiropractic treatment does not succeed,  
21 that there may be a continuation of treatment from the  
22 medical profession.

23 MR. ELLISON: With most compensation cases  
24 the liaison is between the chiropractor and an orthopaedic  
25 specialist or a neuro-surgeon, not with a general practi-  
26 tioner.

27 MR. ESTEY: Yes. And does the Workmen's  
28 Compensation Board administration occasionally bring about  
29 this reference as well from the chiropractic treatment to  
30 the neuro-surgeon or the orthopaedic surgeon?





1 MR. SUTHERLAND: I think that probably  
2 happens.

3 MR. ESTEY: We heard earlier this morning,  
4 I don't think you were here, that under section 51, sub-  
5 section (6), the Board, on occasion, directs the transfer  
6 of a patient from one type of treatment to another either  
7 inside or outside the medical profession.

8 MR. SUTHERLAND: Yes.

9 MR. ESTEY: I was just wondering if the  
10 Board has, on occasion, directed that the orthopaedic treat-  
11 ment be administered to one of your patients?

12 MR. SUTHERLAND: I think this has happened.

13 MR. ELLISON: Usually, a chiropractor may  
14 suggest that the patient be sent to an orthopaedic special-  
15 ist.

16 MR. ESTEY: He suggests that to the Board?

17 MR. ELLISON: Yes, usually after an exten-  
18 sion or two.

19 THE COMMISSIONER: I suppose there are  
20 figures available as to what percentage of these cases which  
21 are the disc type of case, what percentage of them go on  
22 to surgery and what I would like to ask is: Are you acquaint-  
23 ed with any such figures and if so, does the percentage  
24 of them who have been treated by medical men who go on to  
25 surgery any greater than those who had been treated by  
26 chiropractors and go on to surgery?

27 MR. ELLISON: I don't think there are any  
28 figures available but I don't see how there could be any  
29 difference.

30 THE COMMISSIONER: On that level, they are







1 approximately the same?

2 MR. ELLISON: Yes.

3 THE COMMISSIONER: But on another level,  
4 you have a substantial degree of success with that?

5 MR. ELLISON: At the level of a herniated  
6 disc, I think the only treatment is surgery.

7 THE COMMISSIONER: If it is a true hernia  
8 the only treatment is surgery?

9 MR. ELLISON: Yes.

10 MR. ESTEY: Does that same thing apply when  
11 a man goes to a chiropractor as his first choice under the  
12 Act?

13 MR. ELLISON: Sometimes. Sometimes it may  
14 not be made for a week or ten days.

15 MR. ESTEY: Does a chiropractor use Xrays?

16 MR. ELLISON: Yes, sir.

17 THE COMMISSIONER: Well, you don't see  
18 herniated discs in Xrays?

19 MR. ELLISON: You do not.

20 MR. SUTHERLAND: I might point out that in  
21 the statement we read from Dr. Davidson in British Columbia  
22 he was pointing out that the chiropractors diagnose this  
23 problem and then report it to the Board.

24 MR. ESTEY: I notice that.

25 MR. SUTHERLAND: I should mention also  
26 that the diagnosis of a herniated disc is sometimes --

27 THE COMMISSIONER: It can be demonstrated  
28 by trouble in the leg or various other things it might be  
29 related<sup>to;</sup> there are certain sensory tests you use?

30 MR. SUTHERLAND: The term is sometimes used





1 rather loosely. I know Dr. Barbor, when he spoke to the  
2 Toronto Academy of Medicine, mentioned, he drew a definite  
3 distinction between a herniated disc and a protruded disc  
4 which ~~is~~ bulging but not herniated and he claimed that in  
5 his experience, manipulative therapy with the protruding  
6 disc was very effective and was really the treatment of  
7 choice and if it did not succeed, of course, you might  
8 require surgery later.

9 THE COMMISSIONER: That might be the dif-  
10 ference. There are lots of these back troubles that are  
11 suspected as being disc troubles which correct themselves.  
12 They don't all go on to surgery, a lot of them get better.

13 MR. SUTHERLAND: That is right.

14 MR. ELLISON: I don't honestly believe that  
15 anything that gets better was a true **herniated disc**, though.

16 THE COMMISSIONER: Not herniated?

17 MR. ELLISON: Not herniated.

18 THE COMMISSIONER: I think that might be  
19 the distinction.

20 MR. SUTHERLAND: I think a disc that is  
21 under strain and is bulging somewhat, six weeks in bed  
22 might correct it. Manipulation might correct it in a week  
23 but certainly it can be corrected in, I would say, the  
24 majority of cases, perhaps.

25 MR. ESTEY: When the injured workman first  
26 goes to the chiropractor, I take it that the chiropractor  
27 fills out forms that the doctor fills out if he happens to  
28 be the first profession in attendance?

29 MR. SUTHERLAND: Yes, the same thing.

30 MR. ESTEY: That is form 7 and you fill







1 that out and send it in. Now, I take it that the chiro-  
2 practic treatment is no more and no less adequate for the  
3 purpose of determining, which the Board has to determine,  
4 whether or not the injury arose out of the course of his  
5 employment, that is your ability to diagnose and your  
6 experience to diagnose the condition, I take it is no more  
7 or less enlightening to the tribunal that has to make a  
8 decision as to whether or not this fellow should get com-  
9 pensation?

10 MR. SUTHERLAND: I feel, perhaps, Mr.  
11 McDonough might want to comment on this. There is a men-  
12 tion in the medical brief that attracted my attention, the  
13 fact that patients complain of spinal problems after reach-  
14 ing for a stapler, or some small object, and they develop  
15 a severe pain in the back. We feel that this should not  
16 automatically be considered as a workman's desire for time  
17 off. He could have been under stress half an hour earlier  
18 by lifting something heavy or twisting in some way, not  
19 quite enough to bring on the pain but enough to do most of  
20 the damage, and then a sneeze later will be the last straw.  
21 When I was practicing I have had patients come to me after  
22 sneezing and they could hardly stand up. I didn't attribute  
23 this to a sneeze but to the fact that he was lifting cement  
24 block or something just earlier and damaged his spine that  
25 way. Of course, he could have been working at home and  
26 damaged his spine and then reached for something at work.  
27 It is quite a legitimate complaint, I feel, on the worker's  
28 part but it is very difficult to assess exactly when the  
29 strain happened and what was responsible for it.

30 MR. ESTEY: I don't think that any of us





1 intend our questions to be read as aimed at the lead-swingers.  
2 We are not trying to blacken everybody with a spinal pain  
3 as being a lead-swingers, but my question is -- and this is  
4 the reason we are here -- my question is, does the chiro-  
5 practic analysis of the man's condition aid the tribunal  
6 in determining compensability more or less than anybody  
7 else's diagnosis of the condition?

8 MR. SUTHERLAND: I think the chiropractic  
9 analysis of the spinal problem would be helpful, yes.

10 MR. McDONOUGH: It depends on whether the  
11 Compensation Board is primarily interested in the injury --

12 THE COMMISSIONER: I am sorry, I can't hear  
13 you.

14 MR. McDONOUGH: Would not the question be  
15 more meaningful, "just what are you after?" Whether it is  
16 the fact of the injury or the fact of the incident of the  
17 injury or the injury itself. It has been my experience  
18 that the Board has not been concerned primarily about the  
19 injury. This is left up to whoever treats this patient.  
20 The Board is concerned primarily on how this injury took  
21 place and whether it was a compensable injury or not.

22 MR. ESTEY: And what did you say about  
23 that attitude on the part of the Board? I don't follow  
24 that. You say that is good or bad, or is it just a comment?

25 MR. McDONOUGH: No, this is the way it  
26 should be. I have never had the Board argue with me as to  
27 the relative merits of the condition. The only argument I  
28 have ever put up on behalf of the patient or with the in-  
29 dustry, has been as to how this injury was established; in  
30 other words, if four men were lifting a 400 pound boiler





1 and they put it onto its studs and then he went over and  
2 picked up a wrench and never even got to the wrench and his  
3 back let go, he goes into the first aid department and says,  
4 "I have got a strain in my back picking up the wrench". They  
5 never mention the other part. Now, the safety department  
6 will follow this back.

7 MR. ESTEY: This is common to the experience  
8 whether the man goes to an osteopath or the medical doctor  
9 or a chiropractor?

10 MR. McDONOUGH: Yes, that is right, it de-  
11 pends on the person himself.

12 MR. ESTEY: The linkage of the event to the  
13 work or the injury to the work, I take it, is as easily  
14 made or as difficult whether or not the diagnosis is made  
15 by a chiropractor or a person medically trained?

16 MR. McDONOUGH: If the diagnosis is done  
17 according to, you might say, the Compensation Board's  
18 standard, you have certain tests you wanted done under your  
19 regulations.

20 MR. ESTEY: You said that the only argument  
21 you have ever had with the Board or industry was the cause  
22 of the accident, and I take it from that that you are saying  
23 that when you prescribe treatment that the Board has not  
24 second guessed you or interfered with you on the matter of  
25 treatment?

26 MR. McDONOUGH: No, only on whether they  
27 would accept that case as a compensable case.

28 MR. ESTEY: Which again is the cause  
29 problem and not the nature of the injury itself.

30 MR. McDONOUGH: That is right.







1 MR. ESTEY: I take it the next problem you  
2 have, then, is the 17 day limitation?

3 MR. McDONOUGH: This has always been a  
4 problem, but it is only a problem in a minority of cases,  
5 really, that I have found. from my own specific  
6 practice, and that 85 per cent of the cases I have treated  
7 were never lost-time accidents.

8 MR. ESTEY: That is to say, the injuries  
9 do not cause the man to miss any time.

10 MR. McDONOUGH: Yes, that is right, they  
11 are not a lost-time in that sense.

12 MR. ESTEY: Are they recovered within the  
13 17 day period in the main -- in 85 per cent of the cases?

14 MR. McDONOUGH: In the main, yes, but the  
15 exception is the one that requires the extensive amount of  
16 treatment and here is where we have run into difficulty and  
17 we still do in the sense of referral.

18 MR. ESTEY: You have to go back to the  
19 Board for authority to carry on?

20 MR. McDONOUGH: Yes.

21 MR. ESTEY: And the authority is good for  
22 only another 17 days?

23 MR. McDONOUGH: It depends on the instruc-  
24 tions from the Board. I have often been told -- I have  
25 asked for an extension and the Board has advised me to  
26 continue treating the patient as a private patient until  
27 I was notified further, and it may be two or three weeks  
28 before I was notified further.

29 MR. ESTEY: At that time, what would the  
30 Board then say -- "We will not pay for any more"?





1 MR. McDONOUGH: No, usually I am through  
2 the treatment by that particular time, or, if I was having  
3 any difficulty that I thought was beyond me, I would get  
4 in touch myself again with the Board for probably an ortho-  
5 paedic referral or a further extension, depending on whether  
6 there was progress being made. If there was no progress  
7 being made whatsoever, I would stop.

8 MR. ESTEY: Have you had an experience where  
9 the Board has directed orthopaedic referral before you have  
10 recommended it?

11 MR. McDONOUGH: Oh, yes.

12 MR. ESTEY: They have looked at the file  
13 and said that this man should go to an orthopaedic special-  
14 ist?

15 MR. McDONOUGH: Yes.

16 MR. ESTEY: Have you had occasion where  
17 you have disagreed with that?

18 MR. McDONOUGH: It is not a matter of dis-  
19 agreeing. It is a matter -- I will amend that and say that  
20 I will disagree with it in the sense that if I had had an  
21 extension of one week, and I felt the patient was making  
22 progress but needed more time, and they had directed me at  
23 that time to send the patient for orthopaedic consultation,  
24 that in my opinion, at the time, if there was progress  
25 still being made, I would object to the referral.

26 MR. ESTEY: In your ordinary contact with  
27 the Board's medical staff, is your liaison with the ortho-  
28 paedic specialists or is it with neuro-surgeons or neurolo-  
29 gists -- who are they?

30 MR. McDONOUGH: Orthopaedic specialists





1 have been my experience up to now.

2 MR. ESTEY: You practiced in the north --  
3 or do you now?

4 MR. McDONOUGH: I had the Industrial Clinic  
5 in Elliot Lake.

6 MR. ESTEY: That closed when the main mine  
7 closed?

8 MR. McDONOUGH: When everything closed.  
9 We lost our shirts.

10 MR. ESTEY: Where do you practice now?

11 MR. McDONOUGH: I am in Thornhill now.

12 MR. ESTEY: I would like to move on, if I  
13 may, to some of your specific recommendations.

14 THE COMMISSIONER: Before you do that, I  
15 did not fully understand the reference to the voluntary  
16 member of your profession and something to do with the  
17 Board -- what was that?

18 MR. SUTHERLAND: We have appointed what is  
19 called a liaison representative with the Board and he func-  
20 tions as a committee member on our own Board of Directors.  
21 We pay his expenses but he travels to the Board offices as  
22 often as required each month to deal with any problem cases  
23 that may have cropped up or to give any advice from the  
24 chiropractic standpoint. We feel that the amount of work  
25 that we are doing for the Board now merits a full time  
26 consultant.

27 THE COMMISSIONER: He acts as a consultant  
28 with the members of your profession?

29 MR. SUTHERLAND: I will ask Mr. Ellison to  
30 answer this question because he served in this capacity.







1 MR. ELLISON: Mr. Commissioner, this work is  
2 strictly from an administrative standpoint for cases where  
3 proper forms were not sent in, or a case where a chiropractor  
4 did not complete the forms, or where it was not followed up.  
5 He does not diagnose or treat any of the patients.

6 THE COMMISSIONER: Is this voluntary work?

7 MR. ELLISON: It is strictly administrative  
8 work.

9 THE COMMISSIONER: In other words, it is  
10 seeking to help with the inquiries that go back from the  
11 medical supervisor.

12 MR. ELLISON: Yes, he seeks to establish  
13 whether a claim is properly made out, whether it is a com-  
14 pensable case, but he does not interfere in the diagnosis  
15 or treatment of the case at all.

16 THE COMMISSIONER: He has nothing to do  
17 with the Board itself?

18 MR. ELLISON: No.

19 THE COMMISSIONER: Just with the members of  
20 your profession?

21 MR. ELLISON: And the medical aid department.

22 MR. ESTEY: I take it this liaison officer  
23 goes down to the Board office?

24 MR. ELLISON: That is right.

25 MR. ESTEY: Does he have an office there?

26 MR. ELLISON: No. We may have complaints  
27 about chiropractors complaining that the Board has not paid  
28 a certain bill. We get the name and number and talk to the  
29 medical aid department and they look up the file. They, in  
30 turn, may have cases where the forms were not made out





1 properly by certain chiropractors and we get going and try  
2 to get these things straightened out before the Board.

3 MR. ESTEY: One last general topic before  
4 I get into your general recommendations: What is the po-  
5 sition with the practice of the chiropractor in the Armed  
6 Forces.

7 MR. SUTHERLAND: There is no chiropractor  
8 practicing in the Armed Forces. The Department of Veterans  
9 Affairs did pay for the training of 250 chiropractors  
10 through our Canadian College but there is no provision for  
11 the treatment of veterans or in the Armed Forces for the  
12 treatment of personnel.

13 MR. ESTEY: A man on a pension under the  
14 guidance or under the authority of the Canadian Pension  
15 Commission, if he requires treatment for one of the spinal  
16 conditions, I take it from what you say, that the Commission  
17 will not pay for the chiropractor's bill?

18 MR. SUTHERLAND: I should qualify this:  
19 In Manitoba, pensioners are provided with chiropractic  
20 care by the government.

21 MR. ESTEY: I am talking about the Govern-  
22 ment of Canada and the answer to that is no?

23 MR. SUTHERLAND: That is right.

24 THE COMMISSIONER: Perhaps we could adjourn  
25 now and return at 2:00 o'clock.

26 --- Luncheon Adjournment.

27 --- At 2:00 p.m., the Hearing recommenced.

28  
29 MR. ESTEY: Mr. Sutherland, do you have a  
30 copy of the Lacroix Report that you mentioned?





1 MR. SUTHERLAND: Yes, I have.

2 MR. ESTEY: Would you have one that we could  
3 have or borrow?

4 MR. SUTHERLAND: The one I have is a proof  
5 copy of the English edition. The English edition is not  
6 out yet, but we have a pasted up copy we obtained from the  
7 Quebec Government. The others are in the mail and we should  
8 have them, maybe tomorrow.

9 MR. ESTEY: Perhaps you would be good enough  
10 to let us have a copy of the English report when they get  
11 it out?

12 MR. SUTHERLAND: Yes, fine.

13 MR. ESTEY: Perhaps one of the minor con-  
14 siderations that you put forward, at least minor, I am sure  
15 in your opinion, relative to the others, is this question  
16 of the travel mileage. As I understand your recommendation  
17 you want the mileage rate doubled from 50 cents to a dollar  
18 and the terminology changed so that it will not be - the  
19 regulation would not be capable of the interpretation that  
20 you would not get mileage if the patient lived near any  
21 kind of a practitioner?

22 MR. SUTHERLAND: Yes, that is correct.

23 MR. ESTEY: In fact, does the Board apply  
24 item 6 in the schedule of chiropractic fees so that you do  
25 not get paid a mileage when the treatment is administered  
26 in the district of other doctors?

27 MR. SUTHERLAND: Well, I understand from  
28 our liaison officer, Neil Harris, that he inquired about  
29 this at the Board and this is the interpretation he received.

30 MR. ESTEY: Do you know if, in fact though,







1 it has been so interpreted in payment to one of your members?

2 MR. SUTHERLAND: I can't prove that.

3 MR. ESTEY: Is this a common claim in the  
4 routine of examining Workmen's Compensation cases to include  
5 a claim for travel? Do you do that as a regular item of  
6 practice?

7 MR. ELLISON: In suburban areas it is not,  
8 of course, but in rural areas it could be.

9 MR. ESTEY: Would the treatment of compen-  
10 sation cases represent a significant fraction of the general  
11 chiropractic practice in this province?

12 MR. ELLISON: I think that would depend on  
13 the individual practice. I would think, on the average,  
14 it represents maybe 5 per cent but in certain cases -

15 MR. ESTEY: ... it might be higher or lower.

16 MR. ELLISON: I would think in some small  
17 towns it would be negligible but in very industrialized  
18 sections it might go up to 20 or 25 per cent.

19 MR. ESTEY: Your second recommendation is  
20 that patients having back problems which have not responded  
21 under medical treatment should be transferred to chiro-  
22 practors which is what I referred to this morning as the  
23 reciprocity, you would like to have it go both ways?

24 MR. SUTHERLAND: Yes.

25 MR. ESTEY: And I take it that you have  
26 no experience that that has ever happened?

27 MR. SUTHERLAND: No, I don't believe it  
28 has.

29 MR. ESTEY: Would you anticipate that that  
30 might be done sometime without the consent of the injured





1 workman in your proposal?

2 MR. SUTHERLAND: I hadn't thought of it  
3 from that angle, Mr. Estey.

4 MR. ESTEY: I take it it happens now with-  
5 out the workman's consent from the chiropractor to the  
6 doctor?

7 MR. SUTHERLAND: Yes, it has. I think this  
8 would be one benefit of having a chiropractic consultant  
9 at the Board on staff so that the chiropractic assessment  
10 of some of these cases could be made in cooperation with  
11 the medical people and some understanding arrived at.

12 MR. ESTEY: It is fair to say in summary  
13 that your position on your item number 2, is that the  
14 reciprocity should be on the same terms when it moves in  
15 your direction as when it moves in someone else's direction.

16 MR. SUTHERLAND: Yes, I think so.

17 MR. ESTEY: Now, on your item number (3),  
18 you speak of the difficulties of adjudication experience  
19 in connection with spinal injuries. That is why I asked  
20 you earlier whether the treatment or referral, treatment  
21 by or referral to a chiropractor is going to aid the Board  
22 in the adjudication of the injuries of the spinal area and  
23 I take it your answer is that it would be the same assist-  
24 ance as any other interview by another practitioner either  
25 medical or chiropractor or osteopathic, is that correct?

26 MR. SUTHERLAND: I know that some of our  
27 practitioners have been able to assist certain industries  
28 in reducing accidents and time loss by recommending addi-  
29 tional safety factors in industry or putting the man in a  
30 different position so that less stress was placed on the





1 spine. This comes about from his analysis of the spinal  
2 column from our standpoint. I feel that chiropractic  
3 assessment would be helpful perhaps in placing men in jobs  
4 where they were perhaps less prone to develop accidents.

5 MR. ESTEY: This is in rehabilitation or  
6 partial disability cases, but your item 3, I think, deals  
7 with the question of the tribunal having to decide whether  
8 or not there will be compensation and I take it that you  
9 are saying that the report by the chiropractor is of assis-  
10 tance to the tribunal in that phase of the work, that im-  
11 portant phase of their work?

12 MR. ELLISON: I think that, because our  
13 work is associated with the spine in 95 per cent of the  
14 cases, that any help that we could give would be greater  
15 than what a general practitioner could give. I don't  
16 infer that we could be of greater help to the Board than  
17 an orthopaedic specialist or a neuro-surgeon, but in the  
18 general practitioner's case, I believe our help would be  
19 more than they could offer.

20 MR. ESTEY: That is in helping the Board  
21 adjudicate on the entitlement to compensation?

22 MR. ELLISON: Correct.

23 MR. ESTEY: We have talked about your 17  
24 day proposal. Really what you are saying there is that  
25 you want to be on the same basis as the medical practition-  
26 ers?

27 MR. SUTHERLAND: Yes, have the treatment  
28 based on progress reports regularly.

29 MR. ESTEY: And your fifth recommendation  
30 on this question of transfer of the patient from your type







1 of care to medical, I take it, the experience of your member-  
2 ship has been that in those cases there has sometimes been  
3 a delay before treatment resumes under the medical auspices.

4 MR. SUTHERLAND: Yes. I heard of a case  
5 last month in which <sup>the</sup> delay was as much as a month and the  
6 patient finally phoned the chiropractor and said, "Can you  
7 tell me to whom I am to report?"

8 This particular instance turned out to be an oversight and  
9 somebody has mislaid the file, I think, but this type of  
10 thing does happen apparently quite frequently and we feel  
11 it perhaps should be investigated.

12 MR. ESTEY: What would the cause of that  
13 be, that the doctor to whom it has been referred is too busy  
14 to grant an immediate appointment?

15 MR. SUTHERLAND: It could be that the ap-  
16 pointment was made a long time in advance and the man's  
17 treatments had stopped, waiting for this appointment.

18 MR. ESTEY: Would the Board be aware of  
19 that delay before the transfer is made? Does the Board  
20 ascertain the availability of its specialist before they  
21 advise the patient that he has been removed from a chiro-  
22 practor to the orthopaedic specialist for example?

23 MR. SUTHERLAND: I can't answer that ques-  
24 tion, Mr. Estey.

25 MR. ESTEY: On your question of posters,  
26 the posters are now in existence and all you are asking is  
27 that it be set up differently?

28 MR. SUTHERLAND: Yes, we have a copy here,  
29 form 82.

30 MR. ESTEY: One last subject I would like





1 to find out something about. When an injured workman comes  
2 in to see the chiropractor and he has this form filled out  
3 by the employer saying, "This man is employed by me and was  
4 hurt during work and now presents himself for treatment",  
5 you are familiar with that little slip of paper?

6 MR. SUTHERLAND: Yes.

7 MR. ESTEY: I take it that from that point  
8 on the chiropractor treats that man as his patient as though  
9 it were not a Workmen's Compensation case except for the  
10 fact he must also report to the Board?

11 MR. SUTHERLAND: I think so.

12 MR. ESTEY: The same as a doctor?

13 MR. SUTHERLAND: Yes.

14 MR. ESTEY: And if the compensation entitle-  
15 ment is granted then the Board pays the fee; if not the  
16 workman pays the fee. That is the same chiropractically  
17 as it is in medicine, I take it?

18 MR. SUTHERLAND: Yes.

19 MR. ESTEY: And after this stage has been  
20 reached when you are filling out form 8, I take it you  
21 then make your diagnosis because you have to say what is  
22 the injury, or words to that effect?

23 MR. SUTHERLAND: You report the diagnosis  
24 at that time.

25 MR. ESTEY: You have just now seen him  
26 and, I take it, you make it and report it all at the one  
27 time?

28 MR. SUTHERLAND: Yes.

29 MR. ESTEY: And then you take his history  
30 from the man, you put that in the form in which you say





1 there was or there was not prior injury and you also describe  
2 the nature of the event which gave rise to this condition?

3 MR. SUTHERLAND: Yes.

4 MR. ESTEY: So that I take it at that first  
5 meeting you have to decide (a) what is wrong with the man  
6 and (b) how did it happen.

7 MR. SUTHERLAND: Right.

8 MR. ESTEY: When a chiropractor makes a  
9 diagnosis, how does he do it, do you feel the man's spine  
10 and decide from that, or are there tests with galvanic  
11 currents or something you use, or what do you do?

12 MR. SUTHERLAND: First there is a consulta-  
13 tion, of course. Secondly, there is a physical examination  
14 using the usual procedures and tests of different kinds to  
15 assess his condition. These would be similar to those used  
16 by a general practitioner. There may or may not be Xrays  
17 taken, depending upon the nature of the injury and from  
18 this information the diagnosis is arrived at and reported  
19 to the Board. The films are submitted to the Board if they  
20 were taken.

21 MR. ESTEY: How are the Xrays taken in the  
22 case of the chiropractor? Do you send the man to a hos-  
23 pital to have Xrays made in the Xray Department?

24 MR. SUTHERLAND: No, the chiropractors  
25 take their own Xrays.

26 MR. ESTEY: They have their own Xray equip-  
27 ment?

28 MR. SUTHERLAND: That is right, they are  
29 qualified in this procedure during the course.

30 MR. ESTEY: And as a result of that procedure







1 you then fill out the form and send it in and from then on  
2 you are under the 17 day time interval that you told us you  
3 don't like?

4 MR. SUTHERLAND: That is right.

5 MR. ESTEY: For the reasons you have given?

6 MR. SUTHERLAND: Yes.

7 MR. ESTEY: Thank you, Mr. Sutherland.

8 THE COMMISSIONER: Anything further from  
9 your colleagues?

10 MR. SUTHERLAND: No, sir.

11 MR. ESTEY: As a result of the remarks by  
12 the chiropractors as to the advisability of having the os-  
13 teopaths speak for themselves, it might be in the light of  
14 these statements made that their representative, who is  
15 still here, might wish to either endorse that or disagree.

16 MR. DeJARDINE: The representative of the  
17 chiropractors made a few comments about the osteopathic  
18 profession that I would possibly qualify. At one point he  
19 stated that there was no basic difference, he didn't feel  
20 there was any basic difference in manipulative techniques,  
21 that osteopaths treated pretty much the same as the chiro-  
22 practors but that in the United States the osteopathic  
23 profession had added surgery and pharmacology to these  
24 final therapies. Actually, what osteopathy or osteopathic  
25 medicine has done is added to the teaching practice of  
26 medicine, a more comprehensive consideration of the physical  
27 structure of the body than has the regular medical profes-  
28 sion. Manipulative procedures based on the diagnosis made  
29 following the evaluation of the patient, may be the treat-  
30 ment of choice. It may be used in conjunction with other





1 forms of medical treatment.

2 I think possibly that may clarify that point.

3 The osteopathic profession has not been basically a profes-  
4 sion interested primarily in spinal therapy, spinal manipu-  
5 lations at any time in its history. As a matter of fact,  
6 it has not ever, at any time, been a drugless profession,  
7 although we are registered under the Drugless Practitioners  
8 Act here in Ontario, but the osteopathic profession is not  
9 now and never has been a drugless profession.

10 One other minor point. It was mentioned that  
11 the osteopaths in Canada, all across Canada, were restricted  
12 to manipulation. This is not quite so. In the provinces  
13 east of Ontario, there are laws governing our profession in  
14 Nova Scotia and New Brunswick only. To the west the only  
15 restrictions on the practice of medicine by the osteo-  
16 path is in the field of major surgery. In Alberta and  
17 British Columbia the osteopaths are registered by the  
18 College of Physicians and Surgeons in those provinces. In  
19 Saskatchewan and Manitoba there are osteopathic practice  
20 Acts and they do restrict the osteopaths from doing hospital  
21 surgery, major surgery, but in all other fields, drugs,  
22 obstetrics and so on, they are carrying on a type of practice.

23 Thank you.

24 MR. ESTEY: Thank you, Mr. DeJardine.

25 I think International Nickel is now present,  
26 Mr. Commissioner, and have a reference in their brief to  
27 this part.

28 MR. OSLER: Mr. Commissioner, we have what  
29 would appear to be a quite minor point in connection with  
30 this topic and it appears on page 19 of our brief. It





1 might save the time of the Commission, I think, if I merely  
2 stated the situation, and I think it is set out there fairly  
3 fully. Basically, there are two pamphlets, one is circular  
4 G and the other known as Booklet First Aid, each of which  
5 contains a statement that the Board gives the injured work-  
6 man the initial choice of doctor. It has been our experience  
7 that there has been some apparent misunderstanding of this  
8 statement in that certain employees have thought that in the  
9 light of that statement they had the right to be taken to  
10 any doctor in the event of any injury or accident occurring  
11 on the premises of the company, to any doctor they might  
12 choose. I understand from discussions with the Board that  
13 this statement is not really meant to reflect that initial  
14 first aid treatment or initial emergency treatment at the  
15 time of the injury, but rather refers more to the continu-  
16 ing treatment. The particular section of the act involved  
17 is section 61, sub-section 12 and this is where there is a  
18 positive requirement on the part of the employer to furnish  
19 conveyance or transportation to hospital or to a physician  
20 at the workman's home.

21           The major problem really arises where you  
22 have a man who is working at a plant but his home, or the  
23 location of the doctor he normally goes to, is many miles  
24 removed. We have found situations where men living in  
25 Sturgeon Falls, for instance, or areas as far away as that,  
26 and are injured in Sudbury or Coppercliff, feel that they  
27 should be entitled to transportation back to Sturgeon Falls  
28 on the basis of these statements in the pamphlets. Our  
29 contention is that the duty of the employer should be to  
30 remove him to qualified medical or surgical hospital in







1 the area in which the plant is located. This really deals  
2 with nothing more than the transportation.

3 As I say, I think this has really arisen  
4 from a matter of a misunderstanding of the statement in the  
5 circulars.

6 THE COMMISSIONER: What do you say it means?

7 MR. OSLER: I am given to understand from  
8 discussions with officials of the Board that the statement  
9 in these pamphlets merely refers to what you might call the  
10 continuing treatment. The man can choose the doctor from  
11 whom he is going to have continuing treatment, but the  
12 immediate first aid treatment at, or close to, the point  
13 where the man is injured, is really one of taking him to  
14 the first available qualified medical or hospital service.  
15 To give you an example, sir, if we have a man injured at  
16 **Levack**, there is a doctor located in the Town of **Levack**,  
17 and the man would normally be taken there to be given the  
18 treatment. We have had occasion where men are 20 or 30 or  
19 40 miles away -- who live 20 or 30 or 40 miles away from  
20 **Levack** and occasionally they have thought that their right  
21 was to be taken, not to the doctor in **Levack** for treatment,  
22 but taken the 20 or 30 or 40 miles away for treatment there.  
23 As I say, my understanding from discussions with members  
24 of the Board is that the practice to take the injured man  
25 to medical facilities immediately available in the area  
26 is the correct one, but that thereafter the man can choose  
27 the doctor he wishes to be treated by.

28 THE COMMISSIONER: It might have contem-  
29 plated too, the cases where there is no doctor or no one  
30 in the plant.





1 MR. OSLER: The case I am quoting, sir --  
2 this is not the question of a man in the plant at all. It  
3 is a question of taking him to medical facilities which are  
4 closest to the plant. I think to take him home, and so on,  
5 in the Act, may be envisaged there. But with respect, sir,  
6 I do not think industry should be required to take a man  
7 many miles for that treatment.

8 THE COMMISSIONER: There is no interpretation  
9 from the Board, up to the present, that has made you do it?

10 MR. OSLER: No, you are quite correct in  
11 that, but we have had employees under the impression that  
12 they have that right and it just aggravates the situation.

13 MR. ESTEY: Your request is that this  
14 circular G be reworded to make it clear that it refers to  
15 the first emergency treatment?

16 MR. OSLER: Either that or the section in  
17 the Act could be clarified. As I said, it is not a major  
18 point but it is a source of irritation both to the employee  
19 himself, who may think he has certain rights, and the emp-  
20 loyer.

21 THE COMMISSIONER: Thank you.

22 MR. ESTEY: Mr. Commissioner, those are  
23 the briefs to which I have notice that people wish to speak.  
24 I have been asked by the Ontario Medical Association that  
25 one or two of their doctors be afforded an opportunity to  
26 discuss matters which have arisen this morning since they  
27 first spoke.

28 THE COMMISSIONER: Yes, perhaps we had  
29 better go ahead as these doctors may have to get away.

30 DR. YOUNG: Mr. Commissioner, I am Dr.





1 Bruce Young, a specialist in physical medicine and rehabili-  
2 tation. The comments of the chiropractors' brief this  
3 morning prompted me to ask ---

4 THE COMMISSIONER: You are a specialist in  
5 what?

6 DR. YOUNG: Physical medicine and rehabili-  
7 tation. The brief this morning, I would ask consideration  
8 be given that Dr. White's report, which is included in this  
9 brief, be read in context, and in his opening paragraph,  
10 the second sentence ---

11 THE COMMISSIONER: That is the report that  
12 was prepared for the Board?

13 DR. YOUNG: Yes. This report states that  
14 12,000 claims were accepted by the Workmen's Compensation  
15 Board of Ontario. This is referring to low back claims:

16 "In more than one-half of these the  
17 condition does not cause interruption  
18 of the patient's regular work. Only about  
19 10% are disabled longer than six weeks,  
20 but in these the disability is likely to  
21 be very prolonged, and in spite of treat-  
22 ment by orthodox methods during this time  
23 and often for a much longer time, a dis-  
24 abling degree of pain tends to continue,  
25 with little or no improvement."

26 It is in this context that this report was  
27 made and the cases studied then represent a very selective  
28 group of the total cases handled by the Workmen's Compens-  
29 ation Board.

30 THE COMMISSIONER: What do you call that







1 report?

2 DR. YOUNG: This is the report by Dr. A.  
3 W.M. White, Low Back Pain in Men Receiving Workmen's Com-  
4 pensation. It is to be found at the back of the chiro-  
5 practic brief. I felt that in the conclusion of this report,  
6 where Dr. White is quoted as saying that other methods  
7 must be sought, it was other methods for dealing with the  
8 10 per cent of seriously disabled, low back problems and  
9 not for all low back problems that occur under the Workmen's  
10 Compensation Act, which are accepted by the Claims Division.

11 Many of these cases -- and I would be  
12 incorrect to say how many -- had received from my previous  
13 11 years at the Compensation Board, manipulative therapy  
14 under many practitioners, including the chiropractic group.

15 THE COMMISSIONER: His reference was to  
16 the 10 per cent only -- do you want to go on from there?

17 DR. YOUNG: My previous experience of 11  
18 years with the Compensation Board was that many of the  
19 patients accepted for care at the Rehabilitation Hospital,  
20 had, indeed received manipulative therapy from many sources,  
21 not only the chiropractic group. My inference here is  
22 that, indeed, many of these cases had undergone courses  
23 of chiropractic therapy. If I may correct myself -- man-  
24 ipulative therapy.

25 THE COMMISSIONER: Had received manipula-  
26 tive care without a satisfactory result?

27 DR. YOUNG: Without a satisfactory result,  
28 still in the 10 per cent. Along with other forms of  
29 treatment.

30 THE COMMISSIONER: And they came to you





1 eventually?

2 DR. YOUNG: Yes.

3 Dr. Mennell was quoted in this brief and Dr.  
4 Mennell is now in Philadelphia at Temple University and is  
5 no longer in Los Angeles. He has recently been here on a  
6 course for the presentation of manipulative therapy to the  
7 medical profession. His major plea is that the medical  
8 profession become more knowledgeable and accept that manip-  
9 ulative therapy has a place in the management of conditions  
10 of the spinal column. He is very concerned that non-super-  
11 vised and non-medical trained professional personnel practice  
12 in increasing numbers in the manipulative field. It is  
13 his opinion expressed personally in discussion, that this  
14 area of treatment is a medical responsibility. Dr. Mennell  
15 and Dr. Cyriax, who is also quoted, are men who have clinics  
16 and responsibilities and train their therapists to carry  
17 out this form of treatment. I represent a group of whom  
18 there are 17 of us in Ontario, specialists in physical  
19 medicine, who have a very sincere interest in the manage-  
20 ment and views of manipulation and the treatment of soft  
21 tissue and joint conditions. Our concern is that manipu-  
22 lation is, in itself, only one facet of care in many of  
23 these cases and that posture, physical de-conditioning  
24 and many emotional factors must be taken into consideration  
25 before a proper program is possible to be established.

26 Orthopaedic surgeons have approximately  
27 50 per cent of their work in the non-operative management  
28 of bone and joint conditions including the back. Their  
29 group are very much aware of the needs of manipulative  
30 therapy as well as its limitations.





1 It was stated that there is no training.  
2 This group train the students who come under them. I have  
3 just left a post at the University setting where the medical  
4 students received training in manipulative therapy in con-  
5 junction with a total program. The reference made is that  
6 only the chiropractic group should be permitted to perform  
7 manipulative therapy. As a representative of the specialists  
8 in physical medicine and rehabilitation, I would be very  
9 much concerned if such a restriction were placed.

10 In regard to reference back to a chiropractor  
11 in a medical management of a case of low back disability,  
12 in my previous post it was not infrequent that I was asked  
13 at the end of 17 days or 14 days, to review a case and my  
14 instruction from the medical department of the Board was  
15 that, after review, if it was in my opinion that this form  
16 of treatment should or could be continued for the better-  
17 ment of the workman, I would so recommend and this was not  
18 an infrequent recommendation in the practice of my specialty  
19 in that area and this was at the request of the medical  
20 department of the Workmen's Compensation Board.

21 I felt that I would like to bring forward  
22 these observations, Mr. Commissioner, on behalf of the  
23 group that I represent.

24 THE COMMISSIONER: Thank you. The backs  
25 are one of the things that are going to give us trouble.  
26 I am not saying anything about the Board.

27 MR. ESTEY: The only think I didn't under-  
28 stand in that, Doctor, was that you said in the regular  
29 training of a medical student, he is taught as part of  
30 some other course, manipulative treatment, am I correct in







1 that understanding?

2 DR. YOUNG: I said in the setting that I  
3 was in.

4 MR. ESTEY: Is that general in medical  
5 schools in Canada?

6 DR. YOUNG: Where my specialty is represen-  
7 ted, that is true. Now, there are quite a number of  
8 medical schools - for instance the University of Ottawa  
9 had not got this setting, but the orthopaedic group do.

10 MR. ESTEY: So, in the general, under-  
11 graduate medical school, this is not done but it is taught  
12 in some areas where specialties are taught?

13 DR. YOUNG: I am talking basically of the  
14 medical school which has in the specialty groups, the  
15 orthopaedic surgeon for the teaching of the under-graduate  
16 as well as graduate and post-graduate.

17 MR. ESTEY: In that particular school,  
18 that part of the medical treatment includes manipulative  
19 treatment?

20 DR. YOUNG: That is correct.

21 MR. ESTEY: Thank you.

22 Mr. Commissioner, that concludes those  
23 briefs which are going to be presented orally and there  
24 are some now which we have not had presented orally and  
25 which we would not like to proceed and read into the record,  
26 but only that part thereof which deals with today's topic.  
27 I think the first one, here, is the Chiropodists' Brief,  
28 which we might now read in.

29 MR. GUTHRIE: Mr. Commissioner, this is  
30 submitted by the Board of Regents under the Chiropody Act.





1 (1944), Province of Ontario and reads:

2 "INTRODUCTION

3 1. We apologize for the delay in submitting  
4 this brief as we were unaware of the Enquiry  
5 being established. Consequently, we have  
6 been unable to do a complete study of the  
7 Workmen's Compensation Act, however, we  
8 will present a succinct background study of  
9 our profession as to training and qualifi-  
10 cations, inter-professional relationships,  
11 etc. to better acquaint the Enquiry with  
12 our profession, and also include a few  
13 recommendations regarding the Act.

14 2. The Board of Regents under The Chiropody  
15 Act, 1944, of the Province of Ontario  
16 regulates the practice of podiatry in  
17 Ontario.

18 3. Podiatry is 'that specialty of medical  
19 practice which includes the diagnosis and/or  
20 the medical, surgical, mechanical, physical  
21 and adjunctive treatment of the diseases,  
22 injuries and defects of the human foot.'

23 TRAINING AND QUALIFICATIONS

24 4. The Ontario Board of Regents, The  
25 Chiropody Act, 1944 which governs the  
26 practice of podiatry in Ontario, presently  
27 recognizes five colleges, all located in  
28 the United States. These colleges are also  
29 approved by the 'Council on Education' of  
30 the 'Canadian Podiatry Association'. The





colleges, including their curriculum, staff, standard of teaching and physical facilities must be approved and, for such purposes, are periodically examined by the Ontario Board. In addition, graduates of these approved colleges, before being licenced to practice in Ontario, must pass the examination set by the Ontario Board. In addition to Ontario Board approval, it might be noted the 'Council on Education' of the 'American Podiatry Association' is charged with the accrediting of the institutions in the United States. This is an agency recognized as such by the 'Office of Education' of the U.S. Department of Health, Education, Welfare, and the colleges are listed in the Higher Education Directory, Part 111, published by this agency for the U.S. Government. The entrance requirements of the approved colleges are two years pre-professional college study in English, chemistry, physics, biology, etc. Grade thirteen in Ontario is accepted as equivalent to the first year of college. The professional course consists of four years, totalling approximately 4500 hours, of which 3000 are didactic and 1500 are clinical. These approximate hours are divided as follows: The basic science subjects, as taught to all the healing arts, including:







1	Anatomy, Physiology, Pathology,	
2	Microbiology & Chemistry	- 1,100 hrs.
3	Pharmacy	- 200 hrs.
4	Surgery	- 300 hrs.
5	Medicine	- 600 hrs.
6	The specialized podiatric subjects, both	
7	clinical and didactic and including such	
8	subjects as Excrescences, Neoplasms, Infec-	
9	tions, Allergies, Morbid Pathology (osseous	
10	and soft tissue) Deformities and Traumas,	
11	Mechanical Orthopaedics and Clinic	- 2,300 hrs.
12	Total	- 4,500 hrs.

13 All medical and basic science departments  
14 are headed, and in the main, taught by  
15 medical teachers attached to medical colleges,  
16 or medical specialists in private practice.  
17 Where the teacher in a medical or basic  
18 science subject is not a medical man he is  
19 a recognized scientist specializing in that  
20 particular field. The specialized podiatric  
21 subjects are headed and taught by podiatric  
22 teachers. On completion of the professional  
23 course, the student receives the degree  
24 'Doctor of Podiatry' or equivalent degree,  
25 and is eligible to sit for provincial exam-  
26 inations. Podiatry, in both scope of  
27 practice and training, is more akin to  
28 Dentistry than to any of the other associated  
29 medical arts in that neither is, nor can be,  
30 limited to purely palliative treatment. It





is therefore of interest to note that in each case the pre-requisite requirements and professional training are the same, viz., one year pre-professional education after grade thirteen and four years professional training. To demonstrate the respective extent of background medical training, the following comparative table of similar subject matter (other than the respective specialized courses) will be of further interest, namely:

		1964-1965
	Podiatry	U.of Toronto Dentistry
BASIC SCIENCES	1100	973
Pharmacy	200	68
Surgery & Anesthesia	300	163
Medicine	600	218

#### THE GROWTH OF PODIATRY

5. While the Chiropodist of fifty years ago lacked specialized training, today the Podiatrist must have the equivalent of Ontario Grade XIII standing plus one year of university followed by four years of specialized podiatric training.

In accordance with the thinking of his times, the Podiatrist of fifty years ago blamed most foot problems on shoes and treated his patients by palliative means, shoe paddings and wedging, metatarsal bars and 'arch supports'. However, his special-





1            ized interest soon led him to realize the  
2            majority of these conditions were symptoms  
3            of an underlying cause. It became obvious  
4            that the methods in use were not sufficient  
5            to cope with the needs and requirements of  
6            the public for adequate foot health care.  
7            This led to intensified study and research  
8            coupled, (as has occurred in all other  
9            professional fields), with the necessary  
10           extension in training the student in the  
11           podiatric field of diagnosis, medicine and  
12           surgery, so that today, foot problems which  
13           even only a few years ago were considered  
14           intractable, now respond to these new  
15           methods of treatment.

16           With the emphasis on foot rehabilitation and  
17           not the merely palliative, podiatric care  
18           now includes the parenteral employment of  
19           a wide variety of pharmaceuticals, soft  
20           tissue and osseous surgical procedures,  
21           physio-medical modalities and unique foot  
22           prostheses.

#### 23           INTER-PROFESSIONAL RELATIONSHIPS

24           6. The relationship between podiatry and  
25           medicine is, in general, very good, with  
26           no real conflict of interests. As the  
27           editorial in the Canadian Medical Associa-  
28           tion Journal puts it, the Podiatrist is a  
29           '...trained professional man with  
30           professional and ethical standards







1 like our own...', and that he '...  
2 specializes as does the dentist in a  
3 limited field of the body outside of  
4 which he does not venture'.

5 Dr. McDermott in stating the 'Podiatrist ...  
6 of fifty years ago was not a highly trained  
7 man ...' refers to the then medical man's  
8 'suspicion'. Dr. McDermott adds:

9 'This feeling of derogation still  
10 unfortunately exists to some degree  
11 in the minds of too many medical men.  
12 It is only when one sees the high  
13 degree of scientific attainments of  
14 the present day practice of Podiatry  
15 that one sees how completely unfair  
16 and unjustified it is. One sees  
17 now a highly trained man, ethical  
18 and professional in his outlook,  
19 to whom specialists in orthopaedics,  
20 who surely should know what they are  
21 doing, refer their patients constantly  
22 for consultation and treatment, in  
23 the care of those of our patients  
24 who suffer from diseases of the foot.'

25 Physicians who are associated with Podia-  
26 triasts in hospital clinics as well as  
27 those who, in private practice refer  
28 patients to Podiatrists and receive  
29 referrals from them are particularly  
30 familiar with Podiatry and recognize its





1 value to the public health. However, it  
2 must be admitted that while there is a  
3 continuing and ever increasing communication  
4 between the two professions and the situa-  
5 tion has improved immeasurably in the short  
6 period even since Dr. McDermott wrote his  
7 article, a large number of physicians still  
8 do not have the experience and association.  
9 A major reason, of course, is the compara-  
10 tively few Podiatrists in relation to the  
11 number of Physicians practicing in this  
12 Province."

13 THE COMMISSIONER: That is all very inter-  
14 esting.

15 MR. GUTHRIE: I think we are just coming  
16 to the nub of it now, sir.

17 THE COMMISSIONER: They are allowed to  
18 practice?

19 MR. GUTHRIE: Yes.

20 "FREEDOM OF CHOICE OF LICENCED PRACTITIONER"

21 7. Attempts on the part of anyone to limit  
22 the workman, in any way, in his choice of  
23 licensed practitioner, are an unwarranted  
24 interference with the workmen's right of  
25 freedom to choose which licenced practition-  
26 er shall treat him. We, therefore, recommend  
27 that the 'Act' be amended to establish  
28 clearly that the insured have the free  
29 choice of licenced practitioner."

30 THE COMMISSIONER: I thought the Act





1 contained that, or is that simply that the Board permits it  
2 as regulations?

3 MR. GUTHRIE: I think it is just a question  
4 of Board policy. There is no section on it, I don't think.

5 THE COMMISSIONER: Our information is that  
6 the Board indicates it in its regulations, and advertises  
7 it on its posters.

8 MR. GUTHRIE: We saw it in several forms  
9 submitted earlier by Mr. Kerr, the treatment memorandum,  
10 which was the earlier part of Exhibit 8, "The workman has  
11 the initial choice of doctors but may not change doctors  
12 without permission of the Workmen's Compensation Board of  
13 Ontario", and that does appear in other bulletins of that  
14 type, sir.

15 The brief goes on, under the heading of:

16 "DETERMINATION OF PROFESSIONAL FEES

17 8. Physiotherapeutic modalities, and the  
18 use of certain splinting materials and de-  
19 vices, etc., are frequently an integral  
20 part of a podiatric office and when a  
21 workman presents himself for treatment these  
22 measures are immediately carried out for  
23 relief of pain and disability. In order to  
24 have these additional therapeutic services  
25 paid for, prior authorization to use them  
26 is required from the Board. It is not al-  
27 ways possible to receive immediate authoriz-  
28 ation and if finally the Board denies payment  
29 while therapy has been continuing the  
30 practitioner cannot claim payment from the







workman for services rendered.

9. We, therefore, recommend that the Act be amended:

To allow a licenced practitioner to bill a workman directly and that the Board reimburse the workman according to their schedule of fees."

That was the point also made by the osteopaths, I believe, this morning, on direct billing, but I don't understand the reference on the foot of page 5 which says that if the Board doesn't approve the payment of the splinting materials, that the practitioner cannot claim payment from the workman.

THE COMMISSIONER: If the Board doesn't admit the claim.

MR. GUTHRIE: But it would not preclude the practitioner from claiming against the workman.

THE COMMISSIONER: No.

MR. GUTHRIE: Their Summary ...

"I A brief history .... "

THE COMMISSIONER: I was under the impression that medical aid was available even though the claim was later denied.

MR. GUTHRIE: Yes, but when it comes to appliances there may be a difference. I am not sure.

THE COMMISSIONER: That is what he is discussing here.

MR. GUTHRIE: I think it is.

"I A brief history of podiatry as to growth, training and qualifications, and





1 inter-professional relationships has been  
2 related to allay any misunderstandings re-  
3 garding the professional skill and competence  
4 of podiatrists. (ref. Para. 4-5-6)

5 RECOMMENDATION

6 II That the Act be amended to establish  
7 clearly that the insured have the free  
8 choice of licensed practitioner. (ref. para. 7)

9 RECOMMENDATION

10 III That the Act be amended to allow a  
11 licenced practitioner to bill a workman  
12 directly and that the Board reimburse the  
13 workman according their schedule of fees.  
14 (ref. para. 8-0)"

15 THE COMMISSIONER: Would that schedule of  
16 fees refer to the Board's schedule of fees?

17 MR. GUTHRIE: It is not very clear.

18 THE COMMISSIONER: They use the same up  
19 above at the page, Schedule of Fees.

20 MR. GUTHRIE: I would imagine it means the  
21 practitioners' schedule. What schedule is used by the  
22 Board in these cases?

23 MR. KERR: Sir, that would be our own  
24 schedule of fees which is the basis on which we make pay-  
25 ment and there is a section, sub-section (7) of Section 51  
26 which, in effect, prevents the practitioner from charging  
27 the injured person more than that which we pay to the  
28 practitioner. I think perhaps that is what they are refer-  
29 ring to in the brief.

30 MR. GUTHRIE: Yes.





1 Mr. Commissioner, the brief of The Retail  
2 Council of Canada. There are one or two references to this  
3 topic and they have already been presented to you orally by  
4 Mr. McKichan, for the Council. Is it your wish that I refer  
5 to them again at this point?

6 THE COMMISSIONER: You might just refer to  
7 them.

8 The Retail Council of Canada, the first  
9 reference at the foot of page 3 of that brief. It is per-  
10 haps more a matter of reporting. And they have recommended  
11 that employers be kept informed of the progress of their  
12 employees by the receipt of medical reports by the Board.  
13 It is not quite on the topic.

14 However, more in point is the last item on  
15 the brief, on page 5:

16 "RELATIONSHIP WITH MEDICAL PRACTITIONERS

17 14. The Board must rely for the efficient  
18 operation of the Act on the co-operation of  
19 the medical profession and cannot in any  
20 way interfere with the professional deci-  
21 sions of practicing doctors. It is our  
22 belief, however, that it would be to the  
23 benefit of both doctors and their patients  
24 and would facilitate the efficient working  
25 of Workmen's Compensation procedure if some  
26 formal, continuing liaison between the  
27 profession as a whole and the medical staff  
28 of the Board were established. We had in  
29 mind here the distribution of bulletins  
30 and other informative material. We believe







1 for instance, that some doctors may not be  
2 aware of the variety of jobs which are  
3 available in many businesses for employees  
4 suffering from temporary or permanent par-  
5 tial disability, and again, that it may be  
6 worthwhile reminding doctors periodically  
7 of the therapeutic benefits to patients of  
8 their returning as soon as practicable to  
9 work adjusted to their current physical  
10 capability. Presumably the flow of more  
11 specific information on the availability  
12 of rehabilitation services would also be  
13 worhtwhile."

14 I think you may remember, Mr. McKichan  
15 commenting on that, that he felt it was difficult to tell  
16 the doctors what to do, but that some form of bulletin might  
17 remind them of the rehabilitation that was available.

18 The United Electrical Workers, in their brief  
19 have a reference to certain of the regulations dealing with  
20 medical and first aid. It is a short one on page 27.

21 "The regulations governing in-plant medical  
22 and first aid should be reviewed. We do  
23 not believe that the presence of a person  
24 holding 'a St. John Ambulance Senior First  
25 Aid Certificate in good standing, or its  
26 equivalent' is adequate in all circumstances,  
27 or that all types of industry should be  
28 regarded as being the same for purposes  
29 of medical and first aid requirements."  
30 That, I take it, is a reference to the





1 regulations which appear on page 55 of the Office Consoli-  
2 dation of the Act, whereby certain minimum standards are  
3 described for first aid requirements and the staffing of  
4 first aid rooms, depending on the size of the work force  
5 in the place of employment. I think that is the first  
6 reference we have had to those regulations, Mr. Commissioner.

7 In regulation 13 2 (a) we find a reference  
8 to the St. John Certificate and again in 14 2 (a) and 15 2  
9 (b).

10 THE COMMISSIONER: I was wondering when  
11 these circumstances can be made available and how complete  
12 that senior first aid certificate is. You might check  
13 that first time you are calling medical evidence. Do it  
14 when that time comes.

15 MR. GUTHRIE: I think perhaps the Board's  
16 doctor will be able to help us on that.

17 There is a reference in the brief of the  
18 United Steel Workers of America, who will be presenting  
19 that brief in full next week, Mr. Commissioner. But I  
20 think I might, just for the record, note at page 32 of  
21 that brief of the United Steel Workers, there are references  
22 to medical examinations and first aid requirements under  
23 the Mining Act. But as it is part of an over-all topic  
24 relating to Conflicts in Accident Prevention and Inspection  
25 Provisions, I think it had better be left until the brief  
26 is presented in full.

27 I have passed by the Ontario Federation of  
28 Labour, on page 23. Again this has been touched on when  
29 the brief was presented, under another topic.

30 THE COMMISSIONER: Mr. Craigs is here, is





1 he not?

2 MR. GUTHRIE: Would you like to speak to  
3 this Mr. Craigs?

4 MR. CRAIGS: No, I think our position is  
5 clearly set down. We have nothing further to present. The  
6 wording in it is clear.

7 MR. GUTHRIE: I was not aware you were here.

8 MR. CRAIGS: That's quite all right.

9 MR. GUTHRIE: The first part of it was as  
10 to a three day waiting period for medical aid and I think  
11 we already agreed that that was erroneous but the brief  
12 does go along to speak about the free choice of practitioner  
13 and recommends that that right be clearly spelled out in  
14 the legislation:

15 "We believe this section of the Act should  
16 clearly indicate that the workman has a  
17 right to choose his own practitioner."

18 That, Mr. Commissioner, completes the read-  
19 ing in or reference to briefs not submitted orally today  
20 on this topic.

21 MR. ESTEY: Mr. Commissioner, these briefs  
22 today have raised a number of points on which the approp-  
23 riate sections of the Workmen's Compensation Board have  
24 prepared some information for the Royal Commission. I  
25 think Dr. Powell is ready to present that information now.

26 DR. POWELL: Mr. Commissioner, I am Dr.  
27 Powell, Director of Medical Services with the Compensation  
28 Board. I have Mr. George Poole sitting here with me.

29 There are several briefs and we might start  
30 out, if that is all right, sir, with the Board's liaison







1 with the medical profession, unless there are some particu-  
2 lar areas which you wish to inquire about.

3 THE COMMISSIONER: There may be some things  
4 that you have in mind that have arisen from the evidence  
5 that you wish. If you wish to deal with them first, you  
6 are free to do so and then Mr. Estey can probably take  
7 you through the rest.

8 DR. POWELL: PROVISIONS OF THE ACT

9 The Act makes the Board responsible for all  
10 medical aspects of compensable disability.

11 Section 51, subsection 6 provides that "all  
12 questions as to the necessity, character and sufficiency  
13 of any medical aid furnished or to be furnished and as to  
14 payment for medical aid shall be determined by the Board."

15 MEDICAL ORGANIZATION

16 To meet its responsibility under the Act,  
17 the Board has a medical organization under the Director of  
18 Medical Services who reports to the Board on all medical  
19 activities. The medical organization comprises the follow-  
20 ing departments:

21 Advisory Medical and Xray Services  
22 Hospital and Rehabilitation Centre  
23 Medical Aid  
24 Pensions  
25 Chest Services

26 ADVISORY MEDICAL AND XRAY SERVICES

27 Medical Officers and Consultants advise  
28 Claims Officers on medical aspects of claims adjudication  
29 and are located in the Claims Adjudication Area for fast  
30 access to claim files. They are available to the medical





1 profession for information, advice and guidance concerning  
2 treatment of compensable disabilities and carry out exam-  
3 inations of injured workmen on referrals and in difficult  
4 cases.

5 Whenever necessary, patients are Xrayed at  
6 the Board's Offices. The Xray Service also provides advice  
7 and consultation services to the medical profession and to  
8 the Board's medical staff.

9 HOSPITAL AND REHABILITATION CENTRE

10 The Board encourages the use of the best  
11 treatment facilities throughout Ontario. The services of  
12 teaching hospitals and centres for physical medicine are  
13 available to all doctors treating the industrially injured.

14 For specialized care in difficult or unusual  
15 cases, the Board maintains a five hundred and fifty-bed  
16 hospital and Rehabilitation Centre.

17 THE COMMISSIONER: You will excuse me but -  
18 ting in here, the service of teaching hospitals the centres  
19 for physical medicine are available to all doctors treat-  
20 ing the industrial injured. Are you referring to the  
21 doctors on your staff?

22 DR. POWELL: No, sir, not necessarily on  
23 our staff. The profession, as a whole, can certainly  
24 treat patients within teaching centres within university  
25 centres, particularly in the critically injured.

26 THE COMMISSIONER: I just fail to follow  
27 this. Any doctor who has a compensation case come to him,  
28 in what way is he able to make use of these centres for  
29 physical medicine?

30 DR. POWELL: All the facilities of the





1 centre are available to all doctors treating industrially  
2 injured workmen.

3 THE COMMISSIONER: Is there any difference  
4 between an industrially injured workman and anyone else?

5 DR. POWELL: It is a rather unique hospital  
6 where all the facilities are under one parcel. I think  
7 this is the explanation. For instance, general hospitals  
8 are not geared to look after vocational and rehabilitation  
9 problems as the centre is able to do.

10 THE COMMISSIONER: A centre for physical  
11 medicine, is that what you mean?

12 DR. POWELL: Yes, there are other centres  
13 available in the province where an injured workman can be  
14 treated and this is recognized by the Board, particularly  
15 if it is in his own local environs. In the north country,  
16 where these facilities are not available, this is where we  
17 feel the centre plays an unique and particularly important  
18 role, where facilities are lacking.

19 THE COMMISSIONER: I am just trying to  
20 relate this. You are talking about the individual doctor  
21 here: He has the right, then, to use these centres on his  
22 own? He does not have to have authority to go to them  
23 when he refers the man to them for treatment, is that right?

24 DR. POWELL: That is right. This might  
25 explain it a little further, sir:

26 In addition to convalescent care and treat-  
27 ment, special clinics have been organized to deal with the  
28 problems of head injuries, back disabilities and joint  
29 fractures. Approximately four thousand five hundred  
30 patients are treated at the Hospital and Rehabilitation







1 Centre each year with an average stay of thirty-eight days.  
2 All doctors in Ontario are aware of the availability of these  
3 expert facilities.

4 MEDICAL AID

5                   Headed by a doctor, the Medical Aid Depart-  
6 ment is responsible for consideration of all medical  
7 accounts. It consults with medical practitioners and treat-  
8 ment agencies where necessary. The Board's schedule of  
9 medical and surgical fees is based on the Ontario Medical  
10 Association tariff. Agreements exist between the Board and  
11 other professional associations and all such agreements may  
12 be reviewed on request.

13 PENSIONS

14                   The Pensions Department examines patients  
15 who may have permanent disability and determines the amount  
16 of their award. Reports from our own special clinics and  
17 outside consultants are of great benefit in assessing dif-  
18 ficult cases.

19 CHEST SERVICES:

20                   This department operates the Miners' Chest  
21 Examining Stations in Fort William, Elliot Lake, Kirkland  
22 Lake, Sudbury and Timmins under the provisions of the  
23 Mining Act. The department is responsible for the medical  
24 consideration of silicosis, pneumoconiosis and other res-  
25 piratory conditions related to occupational hazards, and  
26 for the annual chest examination of miners.

27                   THE COMMISSIONER: You operate the chest  
28 examination stations at those points. Now, have these chest  
29 examination stations anything to do with the assessment of  
30 liability or assessment of compensation rates?





1 DR. POWELL: No, sir. They are purely  
2 preventative and keeping a record of men exposed to sili-  
3 cosis. This is strictly a medical function.

4 THE COMMISSIONER: Imposed by the Mining  
5 Act?

6 DR. POWELL: Yes. They have Xray facili-  
7 ties and the usual bookkeeping facilities plus being looked  
8 after by doctors.

9 RELATIONSHIP WITH MEDICAL PROFESSION

10 Good liaison between the medical profession  
11 and the Board has existed for many years. The Board's  
12 medical staff maintains continuous contact with those  
13 treating disabled workmen in Ontario and is always avail-  
14 able for consultation or advice in problem cases. The  
15 Director of Medical Services and the Board's Medical  
16 Officers are active in medical society meetings, workshop  
17 groups and seminars. The Board's Medical Handbook is sent  
18 to all medical practioners in this province and other  
19 publications and brochures are available.

20 We have the medical handbooks before you  
21 today, sir.

22 Reports from consultants and the Workmen's  
23 Compensation Board Hospital and Rehabilitation Centre  
24 are forwarded to all doctors treating the patient. The  
25 Board's consultants and medical officers are widely known  
26 in the medical profession and the medical profession is  
27 kept up to date about special facilities at the Hospital  
28 and Rehabilitation Centre.

29 New forms of treatments and things of that  
30 type.





1 RESEARCH PROJECTS

2                   The Board recognizes the need for research  
3 into industrial disability problems and the advantages to be  
4 gained from the progress which results. In addition to the  
5 Back Rehabilitation and General Trauma Clinic, the Head  
6 Injury Conference and Amputation Clinic, the following  
7 research projects have been undertaken, and are currently  
8 being studied:

- 9                   Investigation of Rotator Cuff Injuries of  
10                   the Shoulder Joint
- 11                   Ankle Injuries
- 12                   Caisson Sickness
- 13                   Bladder Stimulating Device. (That is in  
14                   those people who are paraplegics and do  
15                   not have control of their bladder.)
- 16                   Nerve Block Clinic
- 17                   Metatarsal Fractures and Dislocation of  
18                   the Foot
- 19                   Flexor Tendon Injuries
- 20                   Mutilated Hand Injuries and Safety Devices  
21                   (This was delivered at the Ontario Ortho-  
22                   paedic Association trying to correlate the  
23                   injuries of the hand prevalent with certain  
24                   types of machines.)
- 25                   Instant Prostheses for Amputees (In attempt-  
26                   ing to get the man to use his associated  
27                   limbs as quickly as possible.)

28                   We have something here on chiropractic  
29 treatment, sir. We have it, should there be any questions  
30 pertaining to it.







1 PROVISIONS OF THE ACT

2 Section 51, subsection 1 of the Act includes  
3 under medical aid, the aid of drugless practitioners regis-  
4 tered under The Drugless Practitioners Act and the aid of  
5 chiropodists registered under the Chiropody Act.

6 PRACTICAL APPLICATION

7 The workman is allowed to make his initial  
8 choice of attending doctor including drugless practioners.  
9 The Board's treatment responsibilities are derived from the  
10 Act and the Board's administrative policies apply to all  
11 treatment services.

12 BOARD POLICY

13 To ensure expertness of treatment, the Board's  
14 Medical Officers review the course of treatment continuously.

15 If the workman's condition is such that there  
16 is no certainty of prompt recovery, it is considered in  
17 his best interest to have his condition evaluated by a  
18 consultant. As in the supervision of all medical treatment,  
19 this is necessary in order to assess the accuracy of diag-  
20 nosis and efficiency of treatment rendered.

21 BOARD'S EXPERIENCE IN BACK INJURIES

22 Our own studies show that approximately one-  
23 half of our back injury cases in industry do not lay off  
24 work, regardless of who renders treatment. Some 84 per  
25 cent of back cases return to work within four to five weeks  
26 of the work incident. There are a great number of statis-  
27 tics and literature and follow-ups that have come through  
28 the medical profession pertaining to the back in the various  
29 areas and possibly there will be some questions. It is  
30 still a difficult area to pursue, and it has been dealt





1 with or touched on before.

2 QUALITY OF TREATMENT

3 To ensure the highest quality in treatment,  
4 all specialists employed by the Board must be recognized  
5 by the Royal College of Physicians and Surgeons of Canada.  
6 Necessary services in physical medicine and therapy are  
7 already available at the Hospital and Rehabilitation Centre.

8 WORKMEN'S COMPENSATION BOARD POSTERS

9 Wherever there appears to be any misunder-  
10 standing of the provisions of Section 51 of the Act on the  
11 part of the employers, the Board takes prompt action to  
12 acquaint those misinterpreting this section of the Act that  
13 an injured workman is entitled to select a drugless prac-  
14 titioner as attendant.

15 Every new employer is sent a poster, Form  
16 82, when they are covered by the Act. These posters are  
17 revised from time to time and are sent to employers.

18 Any employer can obtain posters on request.

19 THE COMMISSIONER: We will adjourn for a  
20 few moments.

21 --- Short recess.  
22

23 DR. POWELL: Mr. Commissioner, to continue:

24 CHOICE OF DOCTOR OR LICENCED PRACTITIONER

25 THE COMMISSIONER: Before we leave this  
26 last one, there was something I had in mind. Maybe then  
27 you allow your workman to choose his own physician but  
28 as by regulation. There is a submission by two parties here  
29 that it should be in the Act itself and not in the regula-  
30 tions.





1 DR. POWELL: The initial choice, sir, of  
2 physician. This is to prevent the man from shopping and  
3 shopping to get an opinion that he might think is best but  
4 might not be in his best interests.

5 THE COMMISSIONER: Or in your best interests  
6 either, I suppose.

7 DR. POWELL: If there is a failure of the  
8 doctor-patient relationship, a rapport between the doctor  
9 and the man, this does occur, that if the man on application  
10 may want to change, he may do so. There are other reasons  
11 too. A doctor's slate is just too busy, a workman has gone  
12 to visit him and the office has been filled with patients  
13 and he just has not been seen. He might be unhappy in that  
14 direction but, by and large, it is the encouragement of a  
15 man to get his initial doctor and usually to stay with him.

16 THE COMMISSIONER: Well, what does it say  
17 in that little book of regulations? I suppose it is in the  
18 Board's regulations here, is it?

19 MR. POOLE: It is not a regulation, sir, it  
20 is a policy of the Board.

21 THE COMMISSIONER: It is not in the regula-  
22 tions?

23 MR. POOLE: No.

24 MR. KERR: Page 6 of the little book.

25 THE COMMISSIONER: I see.

26 DR. POWELL: ENTITLEMENT TO NECESSARY MEDICAL  
27 AID

28 Under Section 51 of the Act, an injured work-  
29 man is entitled to such medical aid as may be necessary as  
30 a result of the injury.







Subsection 2 of Section 51 states:

"In this Act, 'medical aid' means the medical, surgical and dental aid, the aid of drugless practitioners registered under The Drugless Practitioners Act, the aid of chiropodists registered under The Drugless Practitioners Act, the aid of chiropodists registered under The Chiropody Act, and hospital and skilled nursing services, and, where a workman is rendered helpless through permanent total disability, such other treatment, services or attendance and the artificial member or members and apparatus and repair above-mentioned."

Subsection 6 of Section 51 stipulates that, "All questions as to the necessity, character and sufficiency of any medical aid furnished or to be furnished and as to payment for medical aid shall be determined by the Board."

THE COMMISSIONER: Did you cover the previous page on the payment of medical accounts?

DR. POWELL: No, sir, we will return to that.

#### POSTERS IN PLACES OF EMPLOYMENT

Employers are required to post notices in a conspicuous place accessible to all their workmen. The posters which are supplied to all employers by the Board clearly tell the workman what to do in cases of accident and outline the medical attention to which he is entitled.





1 The poster also tells the workman that he has  
2 the privilege of the initial choice of doctor and that he  
3 cannot subsequently change doctors without the Board's per-  
4 mission. The Board's poster is filed herewith.

5 MR. ESTEY: Do you want to mark that as an  
6 exhibit as you go along?

7 DR. POWELL: Yes.

8 THE COMMISSIONER: Does that appear in more  
9 than one language?

10 DR. POWELL: Only one language, English.

11 MR. ESTEY: Has that appeared before us  
12 before in the bundle?

13 MR. KERR: That was in a bundle of forms,  
14 Exhibit 8.

15 EXHIBIT NO. 21: Workmen's Compensation Board Poster

16 DR. POWELL: FREEDOM OF INITIAL CHOICE OF  
17 DOCTOR

18 While it is not a statutory right under the  
19 Act, the workman has the privilege of the initial choice  
20 of medical practitioner.

21 A governing principle is the immediate need  
22 for treatment which frequently dictates the advisability  
23 of attention by a doctor in the workman's vicinity. It  
24 is generally accepted that the workman will select a  
25 medical practitioner at the nearest point at which adequate  
26 services are available.

27 CHANGE OF DOCTORS

28 A workman cannot change doctors for his  
29 compensable disability without permission from the Board.  
30





1 Exceptions are where he is referred by his attending doctor  
2 to a specialist or where his place of residence is beyond  
3 a reasonable distance from his place of employment and  
4 original treatment. In these cases, the initial attending  
5 doctor is expected to notify the Board to ensure uninter-  
6 rupted medical attention.

7 It is the Board's policy that an injured  
8 workman receive the best possible medical attention. This  
9 is not possible, however, if a workman moves from doctor  
10 to doctor in the hope of obtaining treatment or opinions  
11 more in keeping with his own ideas. The Board believes that  
12 the workman should continue under the care of the doctor  
13 who first attended him and who has a complete record of the  
14 workman's medical condition from the onset of disability.  
15 In difficult cases or at the discretion of the attending  
16 doctor, the Board encourages consultation with and treatment  
17 by the best specialists available.

18 THE COMMISSIONER: Well, of course that is  
19 fluid policy, I suppose you don't stick to it that you  
20 never allow him to change to another doctor?

21 DR. POWELL: It is very fluid, sir. There  
22 is a better rapport, I think.

23 THE COMMISSIONER: Going back to the gener-  
24 ally accepted, the workman will accept the medical practi-  
25 tioner at the nearest point at which adequate services are  
26 available. Do you intend to comment on it at another place  
27 or would you care to do so now, the point that was raised  
28 by Mr. Osler in connection with 51 (12) of the Act?

29 DR. POWELL: Again, we would certainly  
30 encourage the men to attend the nearest place, wherever







1 the facilities for treatment are possible. Of course,  
2 instances do arise when a man is badly injured when he is  
3 brought down to a general hospital or someplace within a  
4 teaching centre for more concentrated treatment, round the  
5 clock nursing services and where there is a multiplicity  
6 of specialists. There are some fall in this category but  
7 by and large, we certainly encourage the man to attend a  
8 doctor in his immediate vicinity to obviate or offset the  
9 idea of going some distance, but I think when a man is  
10 injured, badly injured or hurt, then I think it is up to  
11 the responsibility of the employer to get that man to the  
12 nearest medical facility. I think that is fairly well  
13 spelled out.

14 THE COMMISSIONER: You encourage him to  
15 do that but the man says, "I don't want to go there, I  
16 don't want to go to the Toronto East General Hospital, I  
17 want to go to the Sunnyside one", or something like this.  
18 And he gave as an extreme example where he wanted to go to  
19 some doctor in another community altogether.

20 DR. POWELL: Certainly, in metropolitan  
21 Toronto, I think very often in the small industries a man  
22 is injured and he goes to the local doctor but he may live  
23 across in the other end of town and to go on for subsequent  
24 visits, and particularly at night and possibly on his  
25 own time, it creates a hardship. So that I think the man  
26 should certainly be able to get a doctor within reason  
27 where he lives. The difficulty now, sir, is there are more  
28 and more workmen using the facilities of large general  
29 hospitals and, of course, there is a changing staff all  
30 the time looking after the out-patient and emergency care,





1 so that the initial care is looked after by a doctor and  
2 then the man has to go to his own family doctor to dispose  
3 of some problem because, in effect, there are two doctors  
4 involved, but usually the initial doctor in a general  
5 hospital does not have out-patient care or does not look  
6 after these people subsequently.

7 THE COMMISSIONER: All section (12) says, is  
8 that the employer must furnish immediate conveyance to a  
9 hospital or to a physician or to a workman's home. It does  
10 not say that he has to do it to any particular physician,  
11 but the trouble raised that Mr. Osler referred to was where  
12 the man said, "Well, I am entitled to pick my physician  
13 and this is where I want you to take me". I suppose it  
14 doesn't happen often enough for us to worry about it very  
15 much. It surely can't be very common.

16 MR. POOLE: It is not a common situation,  
17 sir.

18 THE COMMISSIONER: I wouldn't think so,  
19 yes. All right.

20 DR. POWELL: This is the Christian Science  
21 Practitioners and Workmen, Mr. Commissioner and it just  
22 repeats the provisions of the Act.

23 While Section 51 of the Act includes under  
24 medical aid the services of a drugless practitioner regis-  
25 tered under the Drugless Practitioners' Act and the aid  
26 of a Chiropodist registered under the Chiropody Act, there  
27 are no provisions for treatment of injured workmen by  
28 Christian Science Practitioners.

29 THE COMMISSIONER: Christian Science  
30 Practitioners don't come under the term "Drugless Paracti-





1 tioners", I take it.

2 DR. POWELL: They don't, no.

3 THE COMMISSIONER: That term is defined in  
4 the Act, the Drugless Practitioners' Act, is it?

5 DR. POWELL: I don't know, sir.

6 THE COMMISSIONER: Can you tell us, Mr.  
7 DeJardine?

8 MR. DeJARDINE: The Drugless Practitioners'  
9 Act includes a number of groups, the osteopath, the chiro-  
10 practors, physiotherapists, masseurs.

11 THE COMMISSIONER: There is a definition  
12 term, is there, they are specified?

13 MR. DeJARDINE: They are specified by  
14 name. It doesn't mean everybody by name is drugless because  
15 some of us aren't even drugless.

16 THE COMMISSIONER: Does it include Chris-  
17 tian Science Practitioners?

18 MR. DeJARDINE: I don't think it does. I  
19 think at one time it may have, back when it was passed in  
20 1925, but I am not sure.

21 THE COMMISSIONER: I don't know how far  
22 we should ask you as a medical man to comment on what we  
23 have heard hear from Christian Science Practitioners. I  
24 suppose there are cases, maybe many cases where they are  
25 able to do substantial good, but it is a little difficult  
26 to find a basis on which you can pay them for medical  
27 services.

28 DR. POWELL: That is true, I think that we  
29 will all admit the importance of prayer in many things but  
30 as far as including them into the practitioners, I don't







1 know how many practitioners are available and I certainly  
2 am aware that there are not any centres. This probably has  
3 grown up in the States, but as such, I don't think there are  
4 the facilities to cope and I don't know how many workmen  
5 would be involved. This is certainly not a very common  
6 thing, to my knowledge, at the Board.

7 THE COMMISSIONER: I suppose you would be  
8 at a complete loss when you are getting a layman's opinion  
9 of what is wrong with a man.

10 DR. POWELL: It would be extremely difficult,  
11 sir. We would be very loathe.

12 THE COMMISSIONER: I am thinking of a  
13 report from a practitioner, if he made it. He might say  
14 he had a pain in his stomache, or something, and you might  
15 have difficulty in going much further.

16 DR. POWELL: It would be very difficult to  
17 interpret just what the diagnosis is. Of course, we all  
18 know when you have a fractured bone, they even name where  
19 the bone is, but as they point out, so much of our work has  
20 to do with other than fractures, with the subluxations  
21 and dislocations involving joints and livers, spleens,  
22 kidneys and so many other areas, that it would be extremely  
23 difficult, I would imagine, other than to bring the man  
24 down and examine him ourselves, I suppose. In some instances  
25 we can't.

26 THE COMMISSIONER: Well, Mr. Estey may have  
27 some questions for you.

28 MR. ESTEY: You have one more page, I think.

29 DR. POWELL: PAYMENT OF MEDICAL ACCOUNTS  
30 BOARD SOLELY RESPONSIBLE





1 Under the Act, an injured workman is entitled  
2 to all necessary medical aid without cost and the Board is  
3 responsible to the treating agencies for payment of their  
4 accounts. Acceptable schedules of fees have been arranged  
5 through close cooperation between the Board and the various  
6 professional associations and these may be reviewed on  
7 reasonable request. Accounts are paid at 100 per cent of  
8 schedule, without discount or service charge.

9 THE COMMISSIONER: When you say the various  
10 professional associations, what other associations do you  
11 mean?

12 DR. POWELL: The chiropractors, the osteo-  
13 paths, anybody who has a fee schedule.

14 THE COMMISSIONER: The same negotiations  
15 occur with them and arrangements?

16 DR. POWELL: Yes, on discussion.

17 THE COMMISSIONER: I gathered this morning  
18 that they were asked to accept, or told to accept the Ontario  
19 Medical Association's general practitioners' fees.

20 DR. POWELL: The Board goes by the Ontario  
21 Medical Association fairly closely. I think that particular  
22 area is the fact that the chiropractors would put in for  
23 what they think is reasonable and it is not always on a  
24 par with the doctor. It is not always on a par with the  
25 doctors but sometimes equal or sometimes a step below, as  
26 far as payment is concerned.

27 THE COMMISSIONER: Well, Mr. DeJardine  
28 thinks that they ought to have it a step above.

29 DR. POWELL: Yes.

30 THE COMMISSIONER: That is all I am asking.





1 You say by arrangements with the various professional assoc-  
2 iations. What arrangements?

3 DR. POWELL: On request that they want to  
4 come to the Board and see if adjustments can be made in the  
5 fee schedules that they have, and a reasonable charge, an  
6 adjustment was made and then it was re-submitted a month or  
7 two later for further consideration. These things are  
8 considered and discussed, in relation to fee tariff. I  
9 think that is all I have to say on that, sir.

10 In non-schedule or unusual situations,  
11 accounts are considered individually. Indeed many doctors  
12 request the Board to tax their accounts.

13 THE COMMISSIONER: What do you mean by  
14 that?

15 DR. POWELL: Well, for example, plastic  
16 and reconstructive surgery. There may be a mutilated hand.  
17 By the time you add up all the procedures, for example,  
18 it is just out of all proportion, it is much too high and,  
19 of course, there is a certain fee for an initial operation  
20 for a mutilated hand, say \$250 and then there are others,  
21 but to add it up individually and totally would be completely  
22 unreasonable so that contact between our medical aid depart-  
23 ment and the doctor, "What do you think is equitable? What  
24 do you think is fair?" And "This is possibly what I will  
25 be sending in as my account". That is one example.

26 THE COMMISSIONER: All right.

27 DR. POWELL: The Medical Handbook sent to  
28 all medical practitioners in the Province of Ontario gives  
29 full details of fees and incidentals, such as mileage al-  
30 lowances, together with useful general information. The







1 Board's Medical Aid Department is always pleased to deal  
2 with any problems, either by telephone or by letter. The  
3 Board's Medical Handbook is filed herewith.

4 HIGH VOLUME

5 In 1965, 787,988 accounts from all treating  
6 agencies were paid by the Board. Because of the centralized  
7 accounting operation, only 61,865 cheques were issued to  
8 pay these accounts; for instance, 5,486 doctors were paid  
9 during the year for a total of 447,994 accounts. Accounts  
10 are paid on a monthly basis and each cheque is explained  
11 by a detailed listing of the accounts included.

12 Since 1918, this method of payment has  
13 been most acceptable to the medical practitioner.

14 THE COMMISSIONER: Then what about the  
15 last page, Damage to Clothing?

16 DR. POWELL: DAMAGE TO CLOTHING

17 PROVISIONS OF THE ACT

18 Under the Act, a workman who sustains per-  
19 sonal injury by accident is entitled to necessary medical  
20 aid and compensation based on earnings impairment. Where  
21 the accident in the course of the workman's duties results  
22 in damage to an artificial member or apparatus, such as  
23 glasses or dentures, worn by the workman, such damage may  
24 be considered as a personal injury and entitlement granted.

25 WEAR AND TEAR

26 It is recognized that in some circumstances,  
27 artificial appliances such as limbs and leg braces may cause  
28 abnormal wear and tear on clothing.

29 While the Act allows repair and replacement  
30 of artificial appliances provided by the Board, there is





1 no provision for compensation for wear and tear.

2 MR. ESTEY: Dr. Powell, I take it that the  
3 Board has not adopted any regulations for the establishment  
4 of fees payable to any practitioner but rather this is done  
5 by administrative policy?

6 DR. POWELL: That is correct.

7 MR. ESTEY: And that the regulations also  
8 do not set out any entitlement of the workman to select  
9 his own doctor in the first instance, that that also is  
10 fixed by Board policy?

11 DR. POWELL: That is right.

12 MR. ESTEY: I take it that the fees which  
13 you pay practitioners are, looking at your handbook, which  
14 I think we should mark, and which we will, when Mr. Johnston  
15 comes back, if the Commissioner agrees, I see that, in  
16 fact, in your handbook, the schedule of fees is really  
17 the Ontario Medical Association fees, established as the  
18 book says, "After consultations with the Ontario Medical  
19 Association".

20 DR. POWELL: Yes.

21 EXHIBIT NO. 22: Medical handbook.

22  
23 MR. ESTEY: This is the fee which every-  
24 one gets including, I take it, those practitioners who  
25 are not members of the Ontario Medical Association, is  
26 that correct?

27 DR. POWELL: They have a schedule fee of  
28 their own. Actually the chiropractors do.

29 MR. ESTEY: The chiropractors have one;  
30 is that in here?





1 DR. POWELL: No, it isn't.

2 MR. ESTEY: Where would I find that?

3 DR. POWELL: I believe it was attached to  
4 the chiropractors' submission.

5 MR. ESTEY: The little white book?

6 DR. POWELL: Yes.

7 MR. ESTEY: How about the osteopath?

8 DR. POWELL: They are included in the chiro-  
9 practors as well. Now, whether they have received this  
10 booklet separately, I don't know.

11 MR. DeJARDINE: I am not aware of receiving  
12 any booklet whatsoever from the Board about fees.

13 MR. ESTEY: This one says "Schedule of  
14 Chiropractic Fees, Workmen's Compensation Board". Presum-  
15 ably that is a Board publication.

16 DR. POWELL: That is right.

17 MR. ESTEY: How, then, do you pay the osteo-  
18 paths?

19 DR. POWELL: Well, on the schedule of fees  
20 similar to the chiropractors'.

21 MR. ESTEY: Which, also, I take it, is  
22 adopted by Board policy and not fixed by regulation.

23 DR. POWELL: Right.

24 THE COMMISSIONER: On the chiropractors,  
25 you have a different schedule of fees than you do for the  
26 ones in the yellow book?

27 DR. POWELL: Yes.

28 THE COMMISSIONER: But not with the osteopaths?

29 MR. ESTEY: The osteopaths, I suppose, join  
30 in the same comment as the chiropractors, that the schedule







1 of fees, or the policy of determining fees under medical  
2 yardsticks, may not be appropriate to their treatments.  
3 Have you any comments about that? Do you remember it was  
4 said this morning that the number of patients per day  
5 handled by a general practitioner in the medical profession,  
6 would be greater than the number of patients treated per  
7 day by the other two types of practitioners and therefore  
8 the fee schedule would not be appropriate if it was simply  
9 moved from the medical field and put into the osteopaths  
10 and chiropractors. You have any comment on it?

11 DR. POWELL: Other than the fact that they  
12 think they should be considered as specialists in their  
13 particular field and it is true that a specialist, particu-  
14 larly in the medical profession, takes a longer time and  
15 his training and education usually indicates that he is a  
16 specialist and cases have been referred to him by other  
17 doctors, and as such, he has a more regulated time for  
18 study to make the diagnosis. I think this is the same but  
19 I don't think there is a parallel to them at all. I have  
20 no way of knowing what volume of work the osteopaths do.

21 MR. ESTEY: Perhaps we can get at it this  
22 way: Has there ever been <sup>the</sup> in your time or in Board's files,  
23 a record of a discussion between the chiropractors or the  
24 osteopaths or both and the Board as to the standard for  
25 the establishment of fees?

26 DR. POWELL: Oh, indeed. I can't speak  
27 for the osteopaths but we have had several meetings with  
28 the chiropractors or the representative that was alluded  
29 to this morning, Mr. Neil Harris, who, we assumed repres-  
30 ented the chiropractors. He has been in on several





1 occasions discussing fee schedules and particularly on the  
2 mileage basis and various things of that type.

3 MR. ESTEY: Does this issue arise in dis-  
4 cussions with chiropractors about the length of time their  
5 treatment requires as compared to a medical practitioner's  
6 treatment?

7 DR. POWELL: I think, by and large, we are  
8 more stringent, that is, on a medical practitioner, than  
9 we are on chiropractors, in most instances and, certainly,  
10 maybe more demanding. Current accepted treatment was 14  
11 days originally, it is now 17 and the chiropractors said  
12 themselves, "Now I have got a man whom I have treated for  
13 14 days. By the time I make a request to have him treated  
14 or wind the case up another three days has gone by". And  
15 that is why the three days went on to make it 17.

16 MR. ESTEY: I am going to come to that,  
17 Doctor, but on this question of fees right now, the Board  
18 pays an osteopath or a chiropractor for each treatment, the  
19 same way they pay a general practitioner, I take it.

20 DR. POWELL: Yes.

21 MR. ESTEY: Only in the case of a medical  
22 practitioner you have an O.M.A. yardstick which, presumably  
23 applies to the private practice of the doctor as well as  
24 his practice with the Board, is that right?

25 DR. POWELL: Yes.

26 MR. ESTEY: But then when we turn over to  
27 the question of a chiropractor or an osteopath or somebody  
28 else, does the same type of time measurement apply to them  
29 as the Board uses on a medical practitioner?

30 DR. POWELL: I see their objection, but





1 the time limit is not comparable, no.

2 MR. ESTEY: Time for treatment?

3 DR. POWELL: Time for treatment, that is  
4 right.

5 MR. ESTEY: It is not comparable and, there-  
6 fore, if an osteopath received the same per-occasion fee  
7 as a medical doctor receives, but he has to spend twice as  
8 much time, then I take it that arrangement might not be  
9 equitable.

10 DR. POWELL: I have no way of knowing how  
11 long it takes them to make their examination and their  
12 diagnosis.

13 MR. ESTEY: And the osteopaths have not  
14 raised this before in discussions with you, I assume?

15 DR. POWELL: No, they have not.

16 MR. ESTEY: On this same problem, I take  
17 it that the term "doctor" as it appears in the Board regu-  
18 lations and in our terminology, refers to medical practi-  
19 tioners but does not refer to a chiropractor?

20 DR. POWELL: That is correct.

21 MR. ESTEY: Am I right in saying the same  
22 applies in the case of an osteopath, that the term "doctor"  
23 is not intended by the Board to include him?

24 DR. POWELL: That is correct.

25 MR. ESTEY: I ask you that because Circular  
26 G and your poster, form 82, say that the workman has the  
27 initial choice of doctor. Then, form 82 has a footnote on  
28 it which repeats the Act but Circular G has no such foot-  
29 note. I am just wondering whether this circular is intended  
30 as a Board policy to the exclusion of his right to select







1 other than a doctor. I take it that is not possible. There  
2 you are intending that to mean practitioner.

3 DR. POWELL: Yes.

4 MR. ESTEY: "The workman should have the  
5 right of initial choice of a practitioner".

6 DR. POWELL: Yes.

7 MR. ESTEY: Now on your poster, form 82,  
8 I would think that there is perhaps the same objection that  
9 in quick bold type you say he has the initial choice of  
10 doctor and in relatively small type - and I think up on the  
11 wall, insignificant type - it repeats the statute saying,  
12 "medical doctors, drugless practitioners ..." and so on.  
13 I take it the criticism has been leveled before that the  
14 explanation of what is meant by "doctor" is not entirely  
15 clear on the present form 82. Has that come up before?

16 DR. POWELL: Yes.

17 MR. ESTEY: As a matter of fact it is not  
18 the word "doctor" that is qualified in form 82. The aster-  
19 isk relates to the requirement of reporting, the rendition  
20 of medical aid.

21 THE COMMISSIONER: I don't think there has  
22 been any real complaint, though, from either the chiroprac-  
23 tors or the osteopaths about this particular wording in  
24 form 82 and in the other, circular G, we have heard how  
25 the form interprets it. That is a booklet which goes out  
26 to men as well, does it, that little booklet?

27 MR. ESTEY: It says, "For workmen and  
28 employers".

29 THE COMMISSIONER: Then I think it should  
30 be made clear in the booklet.





1 MR. ESTEY: Mr. Guthrie also draws to my  
2 attention the fact that in Exhibit 8 there is the form  
3 that the employer fills out to give to the workman to take  
4 to the treatment centre, whatever that centre is, and  
5 again it says, "The workman - " and this is in large print,  
6 "...has the initial choice of doctor" but that would be the  
7 form the man would have to get if he wanted to go to an  
8 osteopath as well, is it?

9 DR. POWELL: Yes, it is the same one.

10 THE COMMISSIONER: I suppose the workman  
11 thinks of a doctor of osteopathy or a doctor of chiropractic.  
12 It should be clarified on those forms, though.

13 MR. ESTEY: Doctor, we have discussed  
14 this medical aid and perhaps to set the record straight,  
15 or me straight, I take it that the injured workman receives  
16 medical aid under the Act if he is entitled to compensation  
17 in respect of the injury requiring the medical aid or if  
18 he would have received that compensation had it not been  
19 for the three-day waiting period, he then gets medical  
20 aid, is that right?

21 DR. POWELL: Yes.

22 MR. ESTEY: But I take it he doesn't get  
23 medical aid if it doesn't fall within those two categories,  
24 except first aid, which the employer is required to give  
25 him. The employer is required to have first aid facilities  
26 in any case, is that correct?

27 DR. POWELL: Yes.

28 MR. ESTEY: So the medical aid we are  
29 talking about and what you are talking about on page 2,  
30 is that which arises only when he becomes entitled to





1 compensation or would have been but for the three day  
2 period.

3 DR. POWELL: Yes.

4 THE COMMISSIONER: I want to make sure I  
5 understand you. A man goes to a doctor or he says he has  
6 had an accident and goes to his doctor. Is that initial  
7 payment made by the Board under any circumstances?

8 MR. KERR: May I answer that question, sir?  
9 An injured workman is entitled to medical aid even if there  
10 is not loss of time from work and he may have to take an  
11 hour off to go to a doctor and the Board, under the Act,  
12 is responsible to pay for that medical aid which means  
13 that the Board pays for medical aid as a result of that  
14 accident if there is no lost time and certainly when there  
15 is lost time beyond the statutory limitation. I don't  
16 know if we are following the same wave-length but we would  
17 like to clarify that the injured workman is entitled to  
18 medical aid regardless of how long he is off work, whether  
19 it is for half an hour or for three months.

20 THE COMMISSIONER: He is entitled to  
21 medical aid?

22 MR. KERR: Yes, sir.

23 THE COMMISSIONER: Then, supposing he  
24 goes and gets medical aid and then you say, "Well it is  
25 not referable to an accident". What is the situation  
26 there?

27 MR. KERR: In your example, sir, we must,  
28 of necessity, reject the claim. There are two situations  
29 there, sir. If we find that the employer is not under  
30 the Workmen's Compensation Act at all, then we have no







1 authority to pay for that first visit to the doctor. If we  
2 find that the condition diagnosed was not as a result of  
3 the accident reported, we do pay for the first visit to the  
4 doctor because we have used that doctor's report as part of  
5 the information on which we have based a decision to reject  
6 the claim.

7 MR. ESTEY: Thank you, Mr. Kerr. Doctor,  
8 your reference to the Hospital Rehabilitation Centre gives  
9 rise to one question to clarify matters. How does a work-  
10 man get into your Rehabilitation Centre?

11 DR. POWELL: The workman gets into the  
12 Centre by being referred by his surgeon or his physician,  
13 for example, the man has not made the expected recovery  
14 over a particular time; in other words he has been presen-  
15 ted as a problem or a difficult case, not necessarily on  
16 the matter of treatment but in assessment of his vocation,  
17 his aptitude. It may be psychological in testing, he is  
18 intelligent and a battery of other things that are done to  
19 get the man back to suitable or gainful employment, but by  
20 and large it is the attending physician who makes that  
21 decision and there are other areas.

22 MR. ESTEY: Is he then recommended to the  
23 Board and the Board issues the order for the man to go?

24 DR. POWELL: That is right.

25 MR. ESTEY: And I suppose on occasion,  
26 the Board would make the decision from a review of the file?

27 DR. POWELL: That is correct.

28 MR. ESTEY: If there is no response, a long  
29 lack of response to treatment, the Board, occasionally,  
30 will have the man sent in there?





1 DR. POWELL: That is right. And usually  
2 the doctor encourages, and is delighted to have him brought  
3 down.

4 MR. ESTEY: And is the man's consent  
5 necessary to have him put in that hospital?

6 DR. POWELL: It is part of his on-going  
7 treatment. I don't think there are any procedures done.  
8 If there are any on-going progress to have him put in  
9 there, it would be necessary.

10 MR. ESTEY: On that topic, has the Board  
11 any record of any workmen who are objecting to receiving  
12 the treatment offered by the Board through its doctors?

13 DR. POWELL: I don't recall them, there  
14 may be. We do have another set that we do have problems  
15 with, the Jehovah Witnesses, another group that we have  
16 had areas of trouble with.

17 MR. ESTEY: Refusal to take treatment?

18 DR. POWELL: Refusal to be operated upon  
19 where blood was used.

20 MR. ESTEY: What do you do in those  
21 cases?

22 DR. POWELL: They pose a particular problem  
23 but we feel that it is not the Board's responsibility.  
24 Our responsibility stops when we indicate that the surgeon  
25 who is going to do it is qualified by the Royal College.  
26 There are a few cases like that but they have not come to  
27 operation, that is what it amounted to.

28 MR. ESTEY: It is not a very frequent  
29 problem?

30 DR. POWELL: No.





1 MR. ESTEY: Then, you referred to, on page  
2 2, "The Pensions Department examines patients who may have  
3 permanent disability". I take what they do, they have the  
4 attending physician make a report. You don't bring the man  
5 down to Toronto to the Board office and examine him except  
6 on occasion.

7 DR. POWELL: No, some cases can be assessed  
8 for permanent disability without seeing the man. For  
9 example, you can see it by Xray that he has lost a couple  
10 of fingers but by and large, we attempt to see and interview  
11 every man who is entitled to permanent disability and those  
12 who are under, say, 10 per cent awards, they may not be  
13 seen because that is a lump sum type of award.

14 MR. ESTEY: Where do you see these people?

15 DR. POWELL: These are seen down at the  
16 Board's head office on Harbour Street.

17 MR. ESTEY: Not in any regional offices,  
18 but at the head office?

19 DR. POWELL: At the head office, and these  
20 are examined by experts, doctors who are doing this job  
21 continually.

22 MR. ESTEY: And then you have, as you have  
23 described, some chest Xray facilities in the northern part  
24 of the province where you have your own staff at those  
25 centres?

26 DR. POWELL: That is right.

27 MR. ESTEY: Those are permanent centres?

28 DR. POWELL: Permanent centres.

29 MR. ESTEY: Is there any request, or  
30 demand or indicated necessity for enlarging the function







1 of those offices to operate as branch offices of the Board  
2 generally, instead of just as chest Xray centres?

3 DR. POWELL: Yes, attempts have been made  
4 to put somebody in the claims and to answer problems some-  
5 thing similar to our already existing branch offices. In  
6 the north country where we have the mining station, this  
7 has been attempted and, in fact, is in practice.

8 MR. ESTEY: How many branch offices do you  
9 have out in these chest Xray offices?

10 MR. POOLE: We have district offices in  
11 the Lakehead, North Bay, Ottawa, Kitchener, Windsor.

12 MR. ESTEY: In those offices do you have  
13 medical facilities?

14 MR. POOLE: We have no medical facilities  
15 at all. They are chest examining stations and I think  
16 this probably should be explained that these are actually  
17 set up under the Mining Act. It is administering a portion  
18 of the Mining Act and was designed to do it in this manner  
19 so that the cost of operating those centres could be charged  
20 back through the assessment to the mining community. It  
21 also includes the mine rescue, the operation of the mine  
22 rescue station which is also paid out of the same fund by  
23 administrative procedure.

24 MR. ESTEY: I see, thank you, Mr. Poole.

25 DR. POWELL: If I might make a correction.  
26 I mentioned about permanent disability. These men are also  
27 examined in their local areas, that is, doctors go from  
28 the head office out to a local area where these men are  
29 congregated and they may be assessed at some distance from  
30 the Board throughout the province.





1 MR. ESTEY: That is in lieu of bringing  
2 them down here?

3 DR. POWELL: That is right.

4 MR. ESTEY: Then, on this question of the  
5 Board's power to appoint a specialist or to redirect treat-  
6 ment in the course of treatment, I take it that it is a  
7 regular routine that in many cases a general practitioner  
8 will say, "I think this man needs the facilities of an  
9 orthopaedic surgeon and I will recommend to the Board that  
10 he gets it". The Board then decides whether or not that is  
11 going to be done, that is a regular routine?

12 DR. POWELL: It is. It is left up to the  
13 attending doctor to pick a specialist and we encourage him  
14 to do so within his own community, his own area, rather  
15 than bring them down to larger centres.

16 MR. ESTEY: And on occasion, I take it the  
17 Board, on looking at the file, would determine that a  
18 specialist should be brought in?

19 DR. POWELL: Yes.

20 MR. ESTEY: We heard some discussion this  
21 morning that on those occasions the Board does not refer  
22 the man away from the medical profession but amongst the  
23 medical profession or from the chiropractor or osteopath  
24 to the medical profession. Is that correct?

25 DR. POWELL: Yes, it is correct. That is,  
26 when we get into the area where specialists are required,  
27 particularly on complicated and orthopaedic problems, then  
28 by that time it usually means that an orthopaedic specialist  
29 can be selected either by ourselves or by the man's attend-  
30 ing doctor and by and large the case by this time, we feel





1 has got enough problems and enough difficulty in management  
2 to warrant the use of a consultant and sometimes more than  
3 one consultant may be used.

4 MR. ESTEY: My inquiry was more along the  
5 lines of why it is the Board does not find it advisable on  
6 occasion to refer the man to an osteopath.

7 DR. POWELL: For the simple reason we feel  
8 that a qualified orthopaedic surgeon is usually in a posi-  
9 tion to answer, I think, all the questions that an osteo-  
10 path can and probably with having more background experience  
11 because he has seen the pathology, he has operated on many,  
12 many like this.

13 THE COMMISSIONER: Well, he is a specialist.  
14 I think that was recognized by the gentleman who talked  
15 about the chiropractors here today. He seemed to make a  
16 distinction between the cases that went to a specialist.  
17 On the other hand, I guess they think they are specialists  
18 because they deal with backs all the time.

19 MR. ESTEY: I think as a kind of a footnote  
20 to that discussion this morning, we heard references to  
21 the fact, and some this afternoon, that the medical man  
22 might administer the so-called manipulative treatment.  
23 Does that occur on occasion?

24 DR. POWELL: I think it would happen on  
25 occasion, yes, but not too common as far as our work is  
26 concerned.

27 MR. ESTEY: Now, in that connection the  
28 suggestion was made that the Board's services might be  
29 better administered if the Medical Department included in  
30 its number a chiropractor. Has this been considered before?







1 DR. POWELL: It may have been talked about  
2 before but the volume of work, or when there are contentious  
3 problems I think by that time it is more or less out of  
4 the hands of the chiropractor and osteopath to where we  
5 feel probably an orthopaedic surgeon's services are required.

6 THE COMMISSIONER: Does any large proportion  
7 of your claims work go to chiropractors and osteopaths in  
8 relation to the number of them that exist in the province?

9 DR. POWELL: I don't think we have done any  
10 statistical analysis on that, the number that goes. I  
11 think possibly we could find that out.

12 THE COMMISSIONER: A lot do go, though.

13 DR. POWELL: I would say a lot, particularly  
14 again in certain localities. It is fairly common in the  
15 north country.

16 MR. ESTEY: On your medical staff at head  
17 office, you would have an orthopaedic surgeon, you have  
18 several of those, I suppose.

19 DR. POWELL: General surgeon.

20 MR. ESTEY: Do you have more than one of  
21 those?

22 DR. POWELL: We have had two and three.

23 MR. ESTEY: Would you have a neurosurgeon  
24 or a neurologist?

25 DR. POWELL: No, there would not be the  
26 volume to have them there. These are usually located at  
27 the hospital, Rehabilitation Centre at Downsview, and these  
28 are part-time consultants.

29 MR. ESTEY: Private practitioners who  
30 attend there part time?





1 DR. POWELL: But they are usually of prof-  
2 essorial stature connected with the university who have  
3 had in their particular field, an interest in this for  
4 many years.

5 MR. ESTEY: What I was trying to get at  
6 was what type of personnel do you have on your medical  
7 staff in head office, to which the suppliant this morning  
8 wanted to append a chiropractor. What kind of people do  
9 you have down there?

10 DR. POWELL: We have general duty medical  
11 officers. We have some who have been industrial physicians,  
12 medical practitioners and retired surgeons and an internist.  
13 We also have a specialist in occupational skin diseases in  
14 collaboration with a skin specialist. This is how the work  
15 is proportionately divided up.

16 MR. ESTEY: I take it in summary, to get  
17 on to something else, Doctor, that your department's  
18 considered view is that the administration of the Act  
19 could not be assisted by adding a chiropractor to your  
20 staff or adding an osteopath or chiropodist to your staff.

21 DR. POWELL: I would say no.

22 MR. ESTEY: Speaking of the Chiropody Act  
23 brief, I would like to ask, is a chiropodist the same as  
24 a podiatrist?

25 DR. POWELL: Yes, they are synonomous terms.

26 MR. ESTEY: They recommend a number of  
27 things, one being that freedom of choice shall be that of  
28 licenced practitioner instead of a doctor. I take it you  
29 have no comments on that? Your poster purports to announce  
30 that kind of policy.





1 DR. POWELL: Yes. We have very, very few  
2 claims, if I could interrupt, from the chiropody group, very  
3 very few.

4 MR. ESTEY: I was going to ask you that.  
5 I don't think the brief says how many there are. Do you know  
6 that?

7 DR. POWELL: I am not aware. I don't think  
8 it is very common.

9 MR. ESTEY: And they also recommend as do  
10 the chiropractors, that they be allowed to bill a worker  
11 directly and have the Board reimburse them. Have you any  
12 comment on the advisability of that machinery?

13 DR. POWELL: I think it would be very  
14 difficult from the Board's standpoint, from an administra-  
15 tive point of view. Again collecting from the workman,  
16 some of whom might be itinerant and move around a bit, but  
17 I think largely from our standpoint, the system that works  
18 currently we are quite satisfied with and we would be  
19 loathe or unhappy to see any other method used.

20 MR. ESTEY: You have used that since 1918?

21 DR. POWELL: Yes.

22 MR. ESTEY: And you have had no complaints  
23 from the workmen of this practice of paying the doctor  
24 directly?

25 DR. POWELL: We have had no complaints.

26 MR. ESTEY: Now, this change of doctor  
27 policy, again in summary I take it that it is not a very  
28 big question as to whether or not the workman feels some-  
29 what limited in that he can't change horses in mid-stream -  
30 a poor parallel, I don't mean a veterinarian - but he







1 can't change doctors in mid-stream. This is not a practical  
2 problem.

3 DR. POWELL: I don't think it is, sir, no.

4 MR. ESTEY: On occasion you have it and then  
5 what do you do when the workman says, "I want to change  
6 doctors"?

7 DR. POWELL: We go in favour of the workman.  
8 If he says there is some problem, a poor doctor-patient  
9 relationship, we usually know what the problem is and do  
10 everything we can to let him go and see somebody else, but  
11 certainly when it goes on to three and four we would question  
12 it and bring the man into the office and make up our own  
13 minds just what his problem is.

14 MR. ESTEY: Then, one last point. Mr.  
15 Sutherland, speaking for the chiropractors, indicated that  
16 there was difficulty in the sense of a time delay when the  
17 Board intervened and said, "We will now try medical treat-  
18 ment on this man because the chiropractic treatment has  
19 not succeeded" and Mr. Sutherland said that they had noticed  
20 during that time, at least on those occasions, that there  
21 would be a delay before the man was treated by the doctor  
22 in question. Do you know anything about that?

23 DR. POWELL: I think with the volume of  
24 cases we have, I think this could arise but I don't think -  
25 I think it is unfortunate when it does arise and I think  
26 from an administrative standpoint that is our job to see  
27 that it does not occur, but I could not deny it may occur  
28 on occasion but I would say it is not the rule.

29 MR. ESTEY: It would occur, I suppose,  
30 because of the fact that the man would be moving to a





1 specialist, an orthopaedic surgeon or somebody, for which  
2 he would need an appointment.

3 DR. POWELL: And that is difficult to get.

4 MR. ESTEY: Because they are valuable men,  
5 this is difficult to get.

6 DR. POWELL: Yes.

7 MR. ESTEY: I take it that is all you drew  
8 from the comments you heard Mr. Sutherland make?

9 DR. POWELL: Yes.

10 MR. ESTEY: One last question. You say  
11 that the Act does not make provision for compensation to  
12 an injured workman for wear and tear on his clothing occa-  
13 sioned by reason of the fact he has been fitted with some  
14 kind of an appliance. Is that a serious problem? It is  
15 to the man: Is it serious in this way, that you get a  
16 number of these questions arising?

17 DR. POWELL: I would say it is a valid and  
18 reasonable one, yes. They do wear out their clothes.  
19 This is the amputee. Whether this is built into their  
20 assessment, their pension assessment, it is not planned  
21 to do so, but I don't think there is any doubt about it,  
22 they have an abnormal wear and tear on their clothes.

23 MR. ESTEY: Caused by artificial limbs?

24 DR. POWELL: Yes. And the same with ladies  
25 who have to wear the Harris-type brace, their clothes wear  
26 out faster sometimes, particularly with light fabrics.

27 MR. ESTEY: One question which has come  
28 up twice now, and I don't think we have heard much of a  
29 discussion on it: Is there a compensation or indemnifica-  
30 tion to the workman whose clothes are damaged in the





1 accident?

2 DR. POWELL: There is no recognition, no.

3 MR. ESTEY: Is that an important factor?

4 DR. POWELL: Again I suppose it would be  
5 important to the workman at the time but it is not recog-  
6 nized in this jurisdiction.

7 MR. ESTEY: Is the practice of the uniforms  
8 being supplied by the employer a common practice now which  
9 might make this less frequent?

10 MR. POOLE: As a matter of fact, I think  
11 in those circumstances where uniforms are provided by the  
12 employer, the man is usually charged with the damage to the  
13 uniform. This particular clause is in effect in Alberta,  
14 it was just put in a year ago.

15 MR. ESTEY: Where he is entitled to repay-  
16 ment for this?

17 MR. POOLE: Yes, that is the only Act in  
18 Canada that includes it that I know of.

19 THE COMMISSIONER: That is for repayment  
20 for clothes destroyed or damaged in the accident?

21 MR. POOLE: In the accident.

22 THE COMMISSIONER: It doesn't go beyond  
23 that?

24 MR. POOLE: No.

25 MR. ESTEY: Dr. Powell, in the United  
26 Electrical brief at page 27 there is a discussion about  
27 in-plant first aid medical and it says this:

28 "The regulations governing in-plant medical  
29 and first aid should be reviewed. We do  
30 not believe that the presence of a person







1 holding 'a St. John Ambulance Senior First  
2 Aid Certificate in good standing, or its  
3 equivalent' is adequate in all circumstances  
4 or that all types of industry should be  
5 regarded as being the same for the purpose  
6 of medical and first aid requirements."

7 Do you have any requirements about your  
8 present first aid regulations in the light of that sugges-  
9 tion?

10 DR. POWELL: This is based on over 200  
11 plant staff requiring a registered nurse and a man holding  
12 a St. John Ambulance Certificate. Below 200, a man is  
13 satisfactory, in other words a nurse is not required but  
14 a qualified workman with a St. John's Ambulance Certificate.  
15 It is a bit of a paradox because I have seen some well  
16 trained St. John's Ambulance men who were interested and  
17 get dedicated in their work and the same with medical  
18 orderlies who get extremely and awfully proficient in their  
19 work, whereas this may not always be true of a nurse who  
20 has not had the particular training to look after the  
21 numbers of men. I think the ideal thing certainly would  
22 be to have a registered nurse. The difficulty is, of  
23 course, their availability, particularly in areas in the  
24 perimeter of Ontario where it might be difficult to get a  
25 nurse in a plant. I don't know.

26 MR. ESTEY: You are referring to your  
27 regulations 12 to 15?

28 DR. POWELL: Yes.

29 MR. ESTEY: Is there any gradation beyond  
30 200 employees as to requiring more than one nurse or a





1 nurse and a doctor? Is there anything more serious than  
2 regulation 15?

3 DR. POWELL: No, but when the plant gets of  
4 a larger scale, they usually have an industrial physician  
5 on the staff and they have as many as three or four nurses..

6 MR. ESTEY: Is there any demand for such a  
7 regulation or is that a matter that is self-regulated?

8 DR. POWELL: I think it is self-regulated.  
9 I don't think that problem has come up to my knowledge.

10 MR. POOLE: It has not come up.

11 MR. ESTEY: I only have one last question,  
12 or perhaps it might lead to another one. You have a few  
13 thousand reports a year from doctors, I take it, from the  
14 number of bills you pay. You must get almost a million  
15 reports a year from doctors. The suggestion is made that  
16 we need some kind of force in the statute, not directed to  
17 doctors, but my question is: Do you find in the administra-  
18 tion of the Act, dependent as it is upon the validity and  
19 promptness of doctors' reports that there needs to be any  
20 enforcement provisions to ensure that the reports are true  
21 and proper under the Act?

22 DR. POWELL: I would say that we do have  
23 errors of omission and commission and we do have to do a  
24 fair amount of - I don't like the word "enforcing" but we  
25 certainly do everything we can to find out where and why.  
26 Usually it is misunderstanding. A man was not entitled  
27 to compensation where the doctor might have thought in all  
28 honesty and sincerity that he was and then with larger  
29 hospitals treating workmen, that is, after hours, and their  
30 staffs are getting greater and greater, mistakes are made,





1 names are wrong or they can't find a workman and there are  
2 a lot of clerical errors. Diagnosis leaves something to  
3 be desired sometimes but I think after a while you can pretty  
4 well know what the diagnosis should be. There are problems  
5 in that area; I can't help but deny there are in getting  
6 in reports either from a man or from the doctor or from the  
7 employer and it adds up to a fair amount when they are all  
8 taken into consideration. Methods of dealing with these  
9 are constantly being reviewed to see if some better method  
10 or existing method can be improved in getting these reports.

11 MR. ESTEY: I take it that you have been  
12 able to find down through the years no better method of  
13 assessing the man's employability and his length of time  
14 required off from work than to rely on his physician,  
15 because that is what you are doing?

16 DR. POWELL: Yes, that is right.

17 MR. ESTEY: You are relying on the workman's  
18 physician in the vast majority of cases, isn't that true?

19 DR. POWELL: I would say so, yes, his  
20 impression because he would have seen the man and knows  
21 the man and knows a lot of his background and we, at the  
22 Board, don't have the facilities at first.

23 MR. ESTEY: And he, in fact, becomes the  
24 agent of the Board to assess the man's condition and when  
25 he could go back to work?

26 DR. POWELL: He would, yes.

27 MR. ESTEY: One last question: Does the  
28 introduction of OMSIP - and I raise this with some temerity  
29 - raise any question as to the alteration of the relationship  
30 with the Board and the medical profession by reason of the







1 fact that you will have a medical plan which at least in  
2 theory, could become universal? Has the Board considered  
3 this?

4 DR. POWELL: Yes, they have considered  
5 this, but other than the fact of OMSIP billing the man or  
6 paying the man, I think our relationship with this group  
7 should not be too difficult. This, like many other plans,  
8 is difficult when you add them all in - just what it spells  
9 out or which way we are going. Other than the one idea  
10 that, as I say, since 1918 our method of payment has been  
11 satisfactory, that is the only difference I think we would  
12 have with OMSIP.

13 MR. ESTEY: Thank you, Doctor.

14 That, I think, Mr. Commissioner, concludes  
15 matters as regards the topic before the Board, the relation-  
16 ship with the medical profession. We have sent out notices  
17 now, dealing with the next topic which is announced on  
18 page two of our notice of September the 23rd and that is  
19 the topic, still on medicine, of Medical Treatment includ-  
20 ing Silicosis and other Industrial Diseases, Pre-existing  
21 Conditions and Neurosis, all of which are scheduled to  
22 come before the Royal Commission next Monday morning at  
23 ten o'clock, October the 17th.

24 THE COMMISSIONER: One of our difficulties  
25 has been trying to schedule the work so that we will be  
26 able to cover whatever we allot ourselves for individual  
27 weeks and, at the same time, we have sought to avoid  
28 trying to have large gaps at the end of the week, although  
29 we require some time to prepare for the work of the follow-  
30 ing week. In this instance, we appear to have miscalculated





1 a bit. We are all through tonight when I thought it would  
2 take a little bit longer, but the other difficulty we had  
3 was teeing up the work, if I may use the expression, for  
4 next week. We had to arrange with the various medical  
5 experts whom we intend to call, and, as a consequence, we  
6 were unable to fill in the balance of this week.

7 MR. ESTEY: The other difficulty contribut-  
8 ing to our scheduling, Mr. Chairman, is the fact that we  
9 have also coming up next Monday morning at the request of  
10 the United Steel Workers, a presentation of not only that  
11 part of their brief, but matters relating to this week's  
12 business. They could not do it otherwise, so we will start  
13 with them on Monday morning and go into the general brief.

14 THE COMMISSIONER: Well, we are proceeding  
15 as fast as we feel we are able and I hope it is not causing  
16 too much difficulty.

17 We will adjourn until next Monday morning  
18 at 10:00 o'clock.

19 --- (At 4:30 p.m. the Hearing adjourned until 10:00 a.m.  
20 on Monday, 17th of October, 1966.)  
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PROVINCE OF ONTARIO

ROYAL COMMISSION

ON

THE WORKMEN'S COMPENSATION ACT

HEARINGS HELD AT  
TORONTO, ONTARIO

VOL. NO.

11

DATE

17 October 1966

Official Reporters

NETHERCUT & YOUNG LIMITED

48 York Street

TORONTO 1, ONTARIO

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Nethercut & Young

Toronto, Ontario

IN THE MATTER OF THE PUBLIC INQUIRIES  
ACT, R. S. O. 1960, Ch. 323

- and -

IN THE MATTER OF an Inquiry Into and  
Report Upon The Workmen's Compensation  
Act

BEFORE: The Honourable Mr. Justice G. A.  
McGillivray, Commissioner, at  
Room 200, 67 Richmond Street  
West, Toronto, Ontario, on  
Monday, 17th October, 1966

APPEARANCES

W. Z. Estey, B.C., )  
and ) Counsel to the Commission  
H. D. Guthrie )

G. A. Johnston Secretary

ALSO PRESENT:

L. Ingle, J. Dowling,) United Steelworkers of  
and J. Hickey, D. ) America  
Storey )  
Dr. D.J. Clemow Ontario Podiatry Association  
W. R. Kerr Workmen's Compensation Board

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York Street, Toronto, Ontario





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1973 1977

Canadian Federation of Labour	1973
United Steelworkers of America	1977
International Brotherhood of Teamsters	1981

1973-1977, 1981-1985, 1989-1991, 1995-1997, 2001-2003, 2007-2009, 2013-2015, 2019-2021, 2023-2025, 2027-2029, 2031-2033, 2035-2037, 2039-2041, 2043-2045, 2047-2049, 2051-2053, 2055-2057, 2059-2061, 2063-2065, 2067-2069, 2071-2073, 2075-2077, 2079-2081, 2083-2085, 2087-2089, 2091-2093, 2095-2097, 2099-2101, 2103-2105, 2107-2109, 2111-2113, 2115-2117, 2119-2121, 2123-2125, 2127-2129, 2131-2133, 2135-2137, 2139-2141, 2143-2145, 2147-2149, 2151-2153, 2155-2157, 2159-2161, 2163-2165, 2167-2169, 2171-2173, 2175-2177, 2179-2181, 2183-2185, 2187-2189, 2191-2193, 2195-2197, 2199-2201, 2203-2205, 2207-2209, 2211-2213, 2215-2217, 2219-2221, 2223-2225, 2227-2229, 2231-2233, 2235-2237, 2239-2241, 2243-2245, 2247-2249, 2251-2253, 2255-2257, 2259-2261, 2263-2265, 2267-2269, 2271-2273, 2275-2277, 2279-2281, 2283-2285, 2287-2289, 2291-2293, 2295-2297, 2299-2301, 2303-2305, 2307-2309, 2311-2313, 2315-2317, 2319-2321, 2323-2325, 2327-2329, 2331-2333, 2335-2337, 2339-2341, 2343-2345, 2347-2349, 2351-2353, 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5995-5997, 5999-6001, 6003-6005, 6007-6009, 6011-6013, 6015-6017, 6019-6021, 6023-6025, 6027-6029, 6031-6033, 6035-6037, 6039-6041, 6043-6045, 6047-6049, 6051-6053, 6055-6057, 6059-6061, 6063-6065, 6067-6069, 6071-6073, 6075-6077, 6079-6081, 6083-6085, 6087-6089, 6091-6093, 6095-6097, 6099-6101, 6103-6105, 6107-6109, 6111-6113, 6115-6117, 6119-6121, 6123-6125, 6127-6129, 6131-6133, 6135-6137, 6139-6141, 6143-6145, 6147-6149, 6151-6153, 6155-6157, 6159-6161, 6163-6165, 6167-6169, 6171-6173, 6175-6177, 6179-6181, 6183-6185, 6187-6189, 6191-6193, 6195-6197, 6199-6201, 6203-6205, 6207-6209, 6211-6213, 6215-6217, 6219-6221, 6223-6225, 6227-6229, 6231-6233, 6235-6237, 6239-6241, 6243-6245, 6247-6249, 6251-6253, 6255-6257, 6259-6261, 6263-6265, 6267-6269, 6271-6273, 6275-6277, 6279-6281, 6283-6285, 6287-6289, 6291-6293, 6295-6297, 6299-6301, 6303-6305, 6307-6309, 6311-6313, 6315-6317, 6319-6321, 6323-6325, 6327-6329, 6331-6333, 6335-







/SS 1 ---On commencing at ten o'clock a.m.  
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MR. ESTEY: Mr. Commissioner, this morning the representative of The Board of Regents, The Chiropody Act spoke to the Royal Commission staff and asked that they be heard briefly in connection with their brief which they filed and which they were unable to attend and present last week when the other medical matters were filed.

Do you wish to come to the podium, sir?

Would you please give your name and start when you are ready? You might deal with your brief either completely or if you wish to summarize it, feel free to do so.

DR. CLEMOW: My name is Dr. D.J. Clemow I am a Director of the Ontario Podiatry Association. I am not a member of the Board of Regents.

Now, we in the Ontario Podiatry Association are not asking for any additional privileges. We have only submitted a brief on the matter of education. We are under an Act of 1944. We have not been able to update this Act as to our progressive way of podiatry. In the medical brief, in their summarization, Section V, they say:

"That no additional privileges or recognition be granted to practitioners registered under the Drugless Practitioners' Act or the Chiropody Act."

Since we are asking for no additional privileges or





1 recognition, we feel that this may be out of order to  
2 include us in this section.

3 THE CHAIRMAN: I am sorry, I am not  
4 following you. You are referring to what?

5 DR. CLEMOW: The Medical brief which  
6 was submitted.

7 THE COMMISSIONER: The Ontario Medical  
8 Association?

9 DR. CLEMOW: That is right.

10 THE COMMISSIONER: Yes, I follow you.  
11 They recommend that no additional privileges be granted  
12 to practitioners under the Drugless Practitioners' Act  
13 or Chiropody Act.

14 DR. CLEMOW: Yes. Their paragraphs  
15 are 26 to 28. In paragraphs 26 to 28 there is no  
16 reference whatsoever to my profession of chiropody or  
17 prodiatry other than a heading. There is no discussion  
18 in the main body of the brief. We feel this is what  
19 should be deleted. Since they have not discussed it in  
20 the main part of their brief, we ask that the Ontario  
21 Medical Association be approached to remove these last  
22 four words in Section V "or The Chiropody Act."

23 THE COMMISSIONER: Section V of The  
24 Chiropody Act?

25 DR. CLEMOW: No, Section V of the Ontario  
26 Medical Association recommendations.

27 THE COMMISSIONER: Their recommendations?

28 DR. CLEMOW: Yes.

29 MR. ESTEY: What page is that on?

30 DR. CLEMOW: Page 14.





1 THE COMMISSIONER: They have given  
2 evidence here and they haven't made any reference to your  
3 Association at all. I think any remarks of theirs were  
4 directed towards other organizations than yours. I don't  
5 think that I can --- I know the osteopaths objected to  
6 something they had in their brief, but I don't think I  
7 can comment on the Ontario Medical Association's brief  
8 in that respect. If you hadn't mentioned it most people  
9 wouldn't have thought of it. Your submission was read  
10 in the other day, and I judge that the chief, if not the  
11 only thing, you ask is that the Act be amended to ensure  
12 that the patients have a free choice of practitioner.  
13 Isn't this already covered under Section 21?

14 MR. ESTEY: Yes, that is right.

15 THE COMMISSIONER: It is already there.

16 DR. CLEMOW: Under a time limit that the  
17 Workmen's Compensation Act has, we have a time limit of  
18 six weeks to treat a patient. There are some conditions  
19 which require eight to ten weeks. It is legally known  
20 it is so. After six weeks this patient has to be  
21 referred. I can't tell you the section.

22 THE COMMISSIONER: I think it comes  
23 under the regulations. At the end of six weeks they  
24 demand a medical.

25 DR. CLEMOW: That is right.

26 THE COMMISSIONER: By a physician.

27 DR. CLEMOW: Yes, that is right.

28 THE COMMISSIONER: But they are not  
29 necessarily removed from your control.

30 DR. CLEMOW: No. We would like to see







1 it as it is in the Act now, that it is up to the  
2 discretion of the Medical Director to do as he so wishes,  
3 that there is no time limit.

4 THE COMMISSIONER: Do you know what he is  
5 referring to, Mr. Estey? Mr. Kerr could probably tell us.

6 MR. ESTEY: No, I don't know.

7 MR. KERR: No, sir, I am not quite sure  
8 what he is referring to, and I must confess I have no  
9 specific knowledge in this area, but I will obtain it for  
10 you, sir.

11 DR. CLEMOW: As long as something is  
12 done about it, that it is looked into.

13 THE COMMISSIONER: There is a time limit  
14 of six weeks, in which case the man has to submit himself  
15 to an examination by a physician.

16 DR. CLEMOW: We feel it should be left  
17 up to the discretion of the Medical Director. If it is a  
18 fracture it takes eight weeks to heal.

19 THE COMMISSIONER: Your complaint isn't  
20 that he is taken out of your hands at the end of the six  
21 weeks?

22 DR. CLEMOW: No.

23 THE COMMISSIONER: But you feel it is  
24 unnecessary in a case of that kind for an examination  
25 to be held.

26 DR. CLEMOW: We feel it should be up to  
27 the discretion of the Workmen's Compensation Board.

28 MR. ESTEY: And not automatic?

29 DR. CLEMOW: Not automatic.

30 MR. ESTEY: Your recommendation on page 6





1 is that the Act be amended to establish the clear right  
2 of a medical practitioner.

3 DR. CLEMOW: From my knowledge, the  
4 Act does have this.

5 THE COMMISSIONER: It does have it now.

6 MR. ESTEY: No, I don't think that is  
7 right. It doesn't express the right of a medical  
8 practitioner. However, everybody recognizes the right,  
9 but you want it clear in the Act.

10 DR. CLEMOW: Yes. These are the only  
11 two points we had to bring up.

12 THE COMMISSIONER: Your brief description  
13 of the long course and the qualifications of your  
14 various practitioners has been read in. It is a very  
15 good brief. It was read in last week, so you can be  
16 assured it is already before us.

17 DR. CLEMOW: This is an Act which is  
18 22 years old and which should be updated. We hope this  
19 Committee on the Health Services which is being set up  
20 by the government now will deal with that matter. This  
21 is all, sir.

22 THE COMMISSIONER: Thank you very much.

23 MR. ESTEY: We come now, Mr.

24 Commissioner, to the brief filed by the United Steelworkers  
25 of America, to be presented by Mr. Ingle, and I believe  
26 he has some gentlemen with him he may want to introduce.

27 MR. INGLE: I would present to you, sir,  
28 the officers of our Union I have with me this morning.  
29 First of all, our National Director, Mr. Mahoney; our  
30 Assistant National Director, Mr. Park; our Education &





1 Welfare Officer, Mr. Markle. I would like to present our  
2 Legislative Director, Mr. Storey, our Director of Safety,  
3 Mr. Dowling, and the officer from Sudbury in charge of  
4 compensation cases, Mr. Hickey.

5 I may say, sir, that this is one day we  
6 were able to get our officers here, and we do appreciate  
7 the opportunity to have our brief presented today.

8 THE COMMISSIONER: We sought to have it  
9 at another time, but nothing is to be excluded because of  
10 that.

11 MR. INGLE: Thank you, sir.

12 Our union, the largest in Canada,  
13 operates in every province and represents approximately  
14 130,000 employees. In the Province of Ontario we bargain  
15 for over 90,000 employees in the basic steel industry,  
16 non-ferrous metal mining and smelting and the aluminum  
17 and steel fabricating industries. We are affiliated with  
18 the central labour bodies, both nationally and  
19 provincially: The Canadian Labour Congress and The  
20 Ontario Federation of Labour.

21 Our union has had a long and close  
22 association with the Workmen's Compensation Board. While  
23 we are critical of many aspects of the legislation under  
24 which the Board operates, as indicated in this submission,  
25 we should, nevertheless, like to record here our  
26 conviction that the basic conception underlying the  
27 legislation is sound. We believe that despite all  
28 inadequacies of which we are critical the Act has well  
29 served the workmen, employers and general public of  
30 Ontario.







1 We should like to emphasize that the  
2 Act is a Workmen's Compensation Act. Its primary purpose  
3 is to ensure that workmen are properly compensated for  
4 industrial injuries and diseases. It does not exist,  
5 as one employers' group has stated, "for the sole purpose  
6 of administering funds provided by employers in the cause  
7 of employee compensation and accident prevention."  
8 Nor, should I add, sir, is it designed, as another brief  
9 before the Commission has stated, as a means of  
10 preventing hardship from accidents which occur in the  
11 course of employment. It is not granted as a matter of  
12 grace or right. There should be no measure of charity  
13 about it.

14 Finally, we should like to commend the  
15 members of the Board and its staff for the fine job we  
16 believe they are doing, given the legislative framework  
17 within which they have to work. We have always enjoyed  
18 a good relationship with them and have been impressed  
19 with the conscientious way in which their work is done.

20 Now, before I start on the detailed  
21 submission, I wish to say, sir, that I would prefer, if  
22 I may, to read the submission and make comments as I  
23 go along.

24 THE COMMISSIONER: You can proceed as  
25 you see fit.  
26  
27  
28  
29  
30





JN/SS 1 Your submission is a very long one. If, for instance,  
2 in dealing with a particular thing, elimination of waiting  
3 period, it seems to me that having read that if there  
4 is something in particular from one of your officers or  
5 someone else that you wish to have said, then I think  
6 it would probably be a time-saver if we proceeded ---

7 MR. INGLE: All we can say about it  
8 subject to questions ---

9 THE COMMISSIONER: You can still proceed  
10 as you see fit. I will accept it whichever way you do it,  
11 but I am just suggesting that some of the things in any  
12 event you might dispose of while you are there instead of  
13 coming back.

14 MR. INGLE: Thank you very much, my lord.

15 The Commission's attention is respect-  
16 fully drawn to the fact that there is, at present, no  
17 coverage under The Workmen's Compensation Act for people  
18 engaged in rescue work, such as in mining accidents, for  
19 people called out to fight fires under The Fires  
20 Extinguishment Act (R.S.O. 1960, c. 149) or for others  
21 who may be engaged in protecting or attempting to protect  
22 life or property in case of an accident, fire, explosion,  
23 etc., (except the provisions in sec. 122 for those called  
24 on to assist peace officers). The work I have referred  
25 to here is usually fairly dangerous and therefore, in  
26 our opinion, the need for some Workmen's Compensation  
27 protection is even greater than in the ordinary case.  
28 We strongly feel that all such persons should be  
29 protected under the Act and should be entitled to  
30 compensation and medical aid for injuries received during





1 such hazardous work.

2 THE COMMISSIONER: Well, I can understand  
3 the argument in connection with mine rescue work or fire-  
4 fighting. I don't just understand <sup>in</sup> what circumstances  
5 the third of these you mentioned might arise "or others  
6 who may be engaged in protecting or attempting to protect  
7 life or property in case of an accident, fire, explosion,  
8 etc.".

9 MR. INGLE: Well, it is perhaps difficult  
10 to conceive all the situations that might occur, sir. I  
11 do not feel able to define all of them. I draw your  
12 lordship's attention to the fact that other provinces in  
13 providing for this kind of risk have, I think, in every  
14 case, included in addition to explosions and fires  
15 "accidents and other catastrophes".

16 THE COMMISSIONER: I see.

17 MR. INGLE: I have drawn the attention  
18 of the Commission to the provisions of the Manitoba,  
19 Alberta, B. C. and P. E. I. Acts in this connection and  
20 I commend it to your consideration, sir.

21 THE COMMISSIONER: Thank you.

22 With respect to the elimination of the  
23 waiting period it is respectfully submitted that the  
24 waiting period of three days, now provided for in sec.  
25 3 of the Act, should be reduced to the day of accident.  
26 Several other provinces have reduced the waiting  
27 period under their Acts to one day, namely, Alberta,  
28 Manitoba, Newfoundland, Prince Edward Island and  
29 Saskatchewan. The provinces have, for some years now,  
30 successfully operated on this basis without any of the







1 serious consequences which had been predicted if the  
2 waiting period were so reduced.

3 Mr. Justice Roach in his report on  
4 this matter stated that his reason for not recommending  
5 a period less than four working days was the heavy  
6 administration expense in connection with such a reduction  
7 in the waiting period. We have endeavoured here, sir,  
8 to provide some assistance to the Commission in considering  
9 this matter. We draw to the Commission's attention that  
10 in 1951 when the waiting period was reduced from seven to  
11 five days and again in 1963 when the waiting period was  
12 reduced from five to three days there was apparently no  
13 heavy increase in administration costs of the Board.

14 Now, I recognize --- and indeed I may  
15 say that the actual total administration costs, percentage  
16 of costs, was reduced in each of those cases. I recognize  
17 that there may be other factors in the reduction of those  
18 administration costs in those years. One that I would  
19 have guessed was a factor was the increase in the total  
20 number of employees covered under the Act. However, there  
21 are some interesting figures in the report by Mr. Justice  
22 Tysoe in B.C. with which I am sure you are familiar, sir,  
23 on this very thing at pages 86 and 87 of his report.  
24 Their waiting period was reduced in 1959 from six to  
25 three days and in the following year their administration  
26 costs went down from 7.64 to 7.52 per cent at the very  
27 same time when there was an overall reduction in the  
28 number of workmen covered so that that may not be the  
29 whole explanation for the change in administration costs  
30 in Ontario. For whatever it is worth I draw that to your





1 attention, sir. I go on to the contention that it would  
2 appear from the above figures that the reduced period  
3 would in itself result in greatly increased administration  
4 costs has not been borne out by the experience of the  
5 Ontario Board itself. I would like to add this in this  
6 connection, sir, that several of the briefs which have been  
7 submitted to you have drawn attention to the alleged  
8 inequity between the case of a man who is injured before  
9 the weekend and who is thus able to count Saturday and  
10 Sunday in his waiting period to qualify for benefit on  
11 Monday compared with a man who is injured during the  
12 week, and a number of these briefs, as you know, sir,  
13 have requested a change in the wording of Section 3 (1)  
14 (a) from calendar days to working days. I simply point  
15 out here that it is just as inequitable in my opinion,  
16 if not more so, to define the waiting period in terms of  
17 working days because if a man is injured on a Friday  
18 afternoon and is disabled on the Saturday and Sunday if  
19 such a change were made he then could not count the  
20 Saturday and Sunday as part of the waiting period and he  
21 would, in effect, be made to wait for a period of five  
22 days.

23 I suggest that the only way in which  
24 these inequities could be removed is to eliminate the  
25 waiting period itself.

26 Now, with respect to the abolition of  
27 the restriction on compensation to loss of earnings,  
28 it is our respectful submission that compensation should  
29 not be restricted to loss of earnings. Under Section 3  
30 (1)(a) no compensation is payable unless a workman is



disabled for at least three days "from earning full wages".  
If his injury does not disable him from earning full  
wages, he is entitled to no compensation at all --- even  
though his injury may be permanent and seriously interfere  
with his enjoyment of life. Compensation is restricted  
under the Act to pecuniary loss; no compensation is  
payable for personal loss or for many of the things a  
court would take into consideration in awarding general  
damages in personal injury cases. We feel that the  
provision for compensation under the Act in place of the  
individual's right to bring an action is a sound one.  
But we see no reason why an injured person should receive  
less under the Act than he would be entitled to if he  
could bring an action for damages.

Some of the aspects of personal loss  
taken into account in assessing damages in common law  
were stated by Munkman in the second edition of Damages  
for Personal Injury at page 75:

"Where there is permanent  
injury, the damage to be assessed  
may include any or all of the  
following elements: (i) total  
loss, or impairment, of a limb or  
other specific part of the body, or  
impairment of the body as a whole;  
(ii) the shock of the injury,  
sometimes followed by neurosis;  
(iii) physical pain at the time of  
the injury, during surgical  
operations, and perhaps during the







1 rest of life; (iv) mental distress;  
2 (v) <sup>of life</sup> inability to look after the bodily needs  
3 (vi) disfigurement, by scars or  
4 mutilation; (vii) loss of the joys  
5 of life, such as sport, recreation,  
6 music, or the mere ability to walk  
7 about; (viii) shortening of the  
8 natural term of life."

9 None of these elements is taken into account in awarding  
10 compensation under the Ontario Act and the injured  
11 workman is denied the right to recover anything for them  
12 in the courts. A couple of examples will illustrate  
13 the point.

14 An attractive young single girl may be  
15 painfully injured in a plant by scalding steam so that  
16 she is disfigured for life. She may be disabled from  
17 earning full wages for a period of only two or three  
18 months. If she were able to bring an action against her  
19 employer, the court would undoubtedly award a substantial  
20 amount, not only for her pain and suffering, but also  
21 for her disfigurement. But under the Act there is no  
22 authority to pay her anything for either the pain and  
23 suffering or for the disfigurement. Compensation must be  
24 restricted to her loss of earnings and indeed not to  
25 her full loss but to only a percentage of it.

26 An employee may spend his working life  
27 in a plant where the noise level is such that gradually,  
28 over the years, he becomes deaf. In many such cases of  
29 so-called "industrial deafness" his earning capacity  
30 is not adversely affected at all; he can go on working  
at the same job until retirement. But he suffers a very





1 great personal loss in his capacity to communicate with  
2 his family and his friends; to enjoy music and entertain-  
3 ment, etc. There is no authority under the Act to pay  
4 him any compensation because his injury has not disabled  
5 him from earning full wages.

6 We understand that the Board will pay  
7 compensation for industrial deafness six months after  
8 the workman leaves the employment involving the noise  
9 exposure. The Board will also, in certain cases, supply  
10 hearing aids. The legislative authority to do either is,  
11 we submit, most inadequate, if not non-existent.

12 Dr. Keith K. Neely of the Defence  
13 Research Medical Laboratories has made the following  
14 comments on industrial deafness:

15 "There is considerable evidence,  
16 both clinical and experimental to  
17 indicate that exposure over a period  
18 of years to high-intensity noise  
19 whose overall SPL (sound pressure  
20 level) exceeds 85 dB (decibels)  
21 may cause permanent hearing loss.  
22 Some individuals who are highly  
23 susceptible to noise, however, may  
24 sustain permanent loss with less  
25 exposure to lower levels of noise...

26 "The development of such  
27 hearing loss is usually so gradual  
28 and in fact so insidious that the  
29 individual is usually unaware of  
30 his condition until it has become





1 serious. Unfortunately, deafness of  
2 this type, called nerve or perceptive  
3 deafness, is not reversible...

4 "Hearing losses due to exposure  
5 to high-intensity noise whose overall  
6 level does not exceed 150 dB can,  
7 in most instances, be prevented by  
8 using adequate hearing conservation  
9 procedures...

10 "With the knowledge, procedures  
11 and equipment available today, there  
12 is no need for most individuals  
13 exposed to high-intensity noise (85 -  
14 150 dB) to suffer permanent deafness."

15 Report of Third Annual Conference on  
16 Occupational Health and Safety, CLC. Nov. 1964, pp. 36,  
17 38, 39, 48.

18 Unfortunately, since industrial deafness  
19 is not compensable under the Ontario Act, and since the  
20 Act has removed the workman's right of action for such  
21 injuries (as for all others) there is little or no  
22 incentive for employers to take measures to abate noise  
23 or to institute hearing conservation procedures.

24 I may add here, sir, that the suggestion  
25 has been made from time to time that industrial deafness  
26 be added as a disease to Schedule 3 as a compensable  
27 disease. In our submission this would not be the answer.  
28 In the first place, deafness is not considered by the  
29 medical profession to be a disease and even if it were  
30 added to Schedule 3 a person who suffers industrial







1 deafness may still not have any pecuniary loss.

2 One of the anomalies of the Act's  
3 restriction of compensation to pecuniary loss arises in  
4 third party liability under Section 9.

5 THE COMMISSIONER: What you say is adding  
6 it as one of the enumerated heads of Schedule 3 is not  
7 sufficient, that some necessary precautions in accident  
8 work are necessary at the employer level?

9 MR. INGLE: I think that it is not  
10 adequate simply to add it to Schedule 3. Mind you, this  
11 has been done in other provinces. I don't know how their  
12 Acts operate with respect to industrial deafness, but it  
13 seems to me on a logical basis that it is not the whole  
14 solution, because even if a person were deaf and is  
15 covered by Schedule 3 he may still not recover anything  
16 because he has not suffered any loss of wages.

17 THE COMMISSIONER: I am trying to find  
18 out from you what do you say the solution is?

19 MR. INGLE: I think the Act should be  
20 amended, sir, to provide for the payment of compensation  
21 for things other than merely the loss of full wages. There  
22 are provisions in some of the other Acts which I will come  
23 to in a moment which authorize the Board in other  
24 provinces to do just that, and I think that that might be  
25 one of the solutions. I was going to say that one of the  
26 anomalies of the Act's restriction of compensation to  
27 pecuniary loss arises in third party liability under  
28 Section 9. Where the workman elects to claim compensation,  
29 the individual employer (if under Schedule 2) or the Board  
30 (if the employer is under Schedule 1) is subrogated to the





1 workman's right to maintain an action against the third  
2 party. But in any such action there is no restriction on  
3 the damages recoverable such as applies to compensation  
4 under the Act and the employer (or the Board as the case  
5 may be) may claim and obtain compensation for the losses  
6 the workman has suffered over and above the pecuniary  
7 loss for which the Act makes provision.

8 THE COMMISSIONER: Just hold it for a  
9 moment until I re-read that myself. Yes, go ahead.

10 MR. INGLE: A Schedule 2 employer  
11 may, and often does, collect more than he is required to  
12 pay the workman under the Act --- compensation not only  
13 for the loss of earnings over the 75 per cent to which  
14 the claimant under the Act is restricted but also for  
15 the personal loss, including pain and suffering, etc.,  
16 thus making a "profit" out of his employee's injury.  
17 I may say, I have with me now, Mr. Commissioner, a couple  
18 of letters from the Workmen's Compensation Board making  
19 claims against third parties. In this particular case  
20 that I have in front of me there was a claim against the  
21 third party for \$533.00 for wage loss and \$34.50 for a  
22 doctor's bill and hospital expenses where a man suffered  
23 a broken clavical --- I am sorry, a fracture of the right  
24 scapula, and the Board in addition to claiming those  
25 items which are payable under the Act to the workman said  
26 this: "

27 In addition to the above figure he  
28 is entitled to something for his  
29 pain and suffering and I am of the  
30 opinion that \$200 is a reasonable





1 amount in this regard. This makes the  
2 total claim in the amount of \$767.50 "

3 I simply cite this to indicate that this is not at all  
4 unusual and is done all the time in cases of third party  
5 liability.

6 THE COMMISSIONER: I understand that.  
7 Is it not the practice to pay any amount recovered over  
8 and above the cost of compensation to the man himself?

9 MR. INGLE: I was just going to come to  
10 that, sir. I understand that this is the Board's practice  
11 There is nothing requiring them to do so. There is,  
12 however, one large employer ---- and this is a well-known  
13 fact --- in this province who is under Schedule 2 and  
14 who consistently <sup>does</sup> / not pay over such sums to the injured  
15 man. That is the Bell Telephone Company. Mr. Justice  
16 Roach went into this in his report and recommended that  
17 the Act provide specifically in a mandatory way that  
18 such sums recovered in excess of compensation paid, be  
19 paid over to the injured claimant but this proposal was  
20 opposed by employers and his recommendation has not been  
21 implemented.

22 THE COMMISSIONER: Suppose the Bell  
23 Telephone Company--- there was something said here when  
24 Mr. Arnold appeared for them. They had some special  
25 provisions for compensation that they felt took care of  
26 all this sort of thing and he felt their men were better  
27 off in the case of accident than they were in most  
28 industries.

29 MR. INGLE: I am familiar with that  
30 argument and their contention is that any amounts they do







1 retain in this respect are only some small compensation  
2 for other additional privileges and benefits that they  
3 extend to their employees. It seems to me, however, that  
4 it is inequitable that an employee under Schedule 2 ---

5 THE COMMISSIONER: It should be made  
6 clear in the Act?

7 MR. INGLE: That is right.

8 THE COMMISSIONER: That is what Mr.  
9 Justice Roach recommended, is it not?

10 MR. INGLE: That is right, sir, on pages  
11 79 to 83 of his report.

12 It is submitted that workmen should be  
13 fully compensated for their injuries, not just in cases  
14 of third party liability, but in every case, and that  
15 they should receive compensation, not for loss of  
16 earnings alone but for all personal loss such as dis=  
17 figurement, hearing loss, pain and suffering, etc., as  
18 well.

19 The Commission's attention is drawn to  
20 the fact that other provinces have made some concessions  
21 in this direction. And this is what I was referring to  
22 a few moments ago.

23 The Alberta Act (sec. 46 (4)) provides  
24 that:

25 "the Board may, where a workman  
26 has been seriously and permanently  
27 injured about the face or head or  
28 otherwise permanently injured,  
29 recognize an impairment of earning  
30 capacity and may allow lump sums or





1 periodical payments or both, as  
2 compensation".

3 I suggest that that kind of provision would, for example,  
4 cover the illustration of the girl that I mentioned a  
5 moment ago.

6 The Manitoba Act (sec. 28 (2)) has a  
7 similar provision applicable in such cases even though  
8 "the amount which the workman was able to earn before the  
9 accident has not been substantially diminished".

10 MR. ESTEY: Do you have the number of  
11 those sections?

12 MR. INGLE: I am sorry, I was not reading  
13 the references. It is Section 28 (2) of the Manitoba  
14 Act that I was going to refer to, and 22 (2) of the B.C.  
15 Act, which is similar to that in Manitoba ---

16 Section 39 (1) (a) of the Nova Scotia  
17 Act and Section 6 (1) (a) of the Prince Edward Island Act  
18 give the respective Boards of those provinces  
19 discretionary authority to pay compensation "notwith-  
20 standing that such personal injury does not disable the  
21 workman for four days from earning full wages at the  
22 work at which he was employed."

23 Other extensions we recommend, beyond  
24 loss of earnings and medical aid, are compensation for  
25 any articles of clothing destroyed or damaged as a result  
26 of a compensable accident and for dentures, artificial  
27 limbs or eyeglasses broken in such an accident.

28 THE COMMISSIONER: I want to go back to  
29 the last paragraph. I don't fully understand this  
30 section that you refer to in the P. E. I. Act,





1 "notwithstanding that such personal injury does not  
2 disable the workman for four days from earning full wages  
3 at the work at which he was employed". In other words,  
4 why do they have the four-day thing in there?

5 MR. INGLE: That is their waiting period,  
6 I believe.

7 THE COMMISSIONER: I know it is their  
8 waiting period, but this would seem to wash out the  
9 waiting period, wouldn't it?

10 MR. INGLE: No, I don't think so, sir.  
11 It may be poor draftsmanship, but I think the intention  
12 here is that compensation may be paid even though there  
13 is no loss of wages even for the waiting period. I don't  
14 think it intends to modify the waiting period at all.  
15 I think perhaps that is poor draftsmanship, I agree with  
16 you, but I think the intention is to cover the kind of  
17 situation I have referred to. I think personally that  
18 the wording in the Manitoba Act and British Columbia Act  
19 is preferable.

20 If eyeglasses, artificial limbs or  
21 dentures are actually being worn when a compensable  
22 accident occurs, in which they are broken, the Board's  
23 present practice is to make an allowance for them. There  
24 should, however, be legislative authority for such  
25 payment and it should be extended to all such damage  
26 resulting from a compensable accident. If, for example,  
27 a man's glasses are in his pocket and he has an accident  
28 in which those glasses are broken he is not paid for  
29 them. If, indeed, instead he had them on his forehead  
30 like this the Board, I understand, would not make any







1 allowance for them.

2 THE COMMISSIONER: I suppose one of the  
3 reasons is that I have my glasses in my vest pocket a  
4 great deal of the time and every once in a while I break  
5 them when I start doing some manual labour or something  
6 that works up against there, but that is my own  
7 carelessness. I have not had them in a proper box or  
8 something of the kind.

9 MR. INGLE: We are only making this  
10 suggestion, sir, in the cases where there is a compensable  
11 accident, that is all.

12 THE COMMISSIONER: I see, yes. Where a  
13 compensable accident occurs.

14 MR. INGLE: That is correct.

15 Where an injury for which a workman  
16 receives compensation is of such a nature that he must  
17 wear a prosthetic device, an allowance for clothing should  
18 be paid by the Board for any additional deterioration  
19 of clothes caused by the wearing of such a device. The  
20 Board's attention is respectfully drawn to Section 22 of  
21 the Manitoba Act, Section 25 (8) of the B.C. Act and  
22 Section 50a of the Alberta Act, which contain provisions  
23 similar to those recommended here.

24 ELIMINATION OF SCHEDULE 2 OF THE ACT

25 Under Section 5 of the Act, certain  
26 employers, those covered by Schedule 2, are liable  
27 directly and individually to pay compensation and medical aid  
28 to their injured employees. They include, inter alia,  
29 municipalities, school boards, public utility commissions,  
30 public libraries, public transit companies, steamship,





1 ferry-boat and tug-boat operators, ship-building  
2 companies, telephone companies and railways as well as  
3 the Crown in right of Ontario. Because there is no  
4 registration or other record of employers under Schedule  
5 2 until an injury to an employee is reported to the  
6 Board, there is no accurate count of the number of  
7 employers or the total number of their employees who come  
8 under Schedule 2. It is estimated, however, that the  
9 number of such employers may be between eight and ten  
10 thousand.

11 When he drafted the original act in  
12 1914, the late Chief Justice Meredith, in proposing the  
13 direct liability of this group of employers, stated that  
14 he did so "in order that with the two systems working  
15 side by side, experience might demonstrate whether the  
16 collective system or that of individual liability was  
17 preferable." And the implication I take from that is  
18 that once either one of those propositions was  
19 demonstrated then all employers would be brought under  
20 the better of the two systems.

21 It is respectfully submitted that the  
22 half a century the system has been in operation has been  
23 more than sufficient for the demonstration and that this  
24 division of Ontario employers and employees into two  
25 different classes for the purposes of compensation should  
26 be brought to an end. The principle of collective  
27 responsibility, incorporated in Schedule 1, should be  
28 applied to all employers and employees in the province  
29 without distinction.

30 It is our impression, though we are





1 unable to document it, that claims for compensation by  
2 employees under Schedule 2 are much more vigorously  
3 contested than claims under Schedule 1. The Honourable  
4 Mr. Justice W. E. Middleton, in his report of February  
5 11, 1932, stated as much when, in dealing with Schedule  
6 2, he said:

7 "In the case of the railway or  
8 other large concern, while there is  
9 undoubtedly sympathy for the injured  
10 man, there is a keen and close  
11 investigation into the nature and  
12 extent of the injury received, and  
13 there is a desire to minimize the  
14 incapacity of the workman and so to  
15 minimize the loss to the company.  
16 There is no room for suggestion that  
17 the medical men employed by the  
18 company are not admirably qualified  
19 and thoroughly honest, but everything  
20 is viewed from the standpoint of  
21 the employer and there is not quite  
22 the same sympathetic and generous  
23 attitude as in cases where the  
24 injured man alone is considered, and the  
25 payment is made from an impersonal  
26 fund to which the employer contributes  
27 an infinitesimal fraction".

28 It should be noted that at the time Mr. Justice Middleton  
29 made his report, medical aid was provided directly by  
30 the railway employer's own medical staff. Despite what







1 the learned Commissioner said about the competence and  
2 honesty of the medical men employed by the Schedule 2  
3 employers, after some serious accidents in 1945 a change  
4 was made, effective 1 July 1945, so that thereafter  
5 medical aid for Schedule 2 employees has been provided  
6 in the same manner as for employees under Schedule 1.

7 The Board should be able to provide  
8 the Commission with detailed information as to the  
9 proportion of claims contested by employers under Schedule  
10 2 as compared with contested claims under Schedule 1.

11 THE COMMISSIONER: Tell me this: What is  
12 wrong with the employer under Schedule 2 making a careful  
13 inquiry and if he thinks it is proper protesting it  
14 before the Board?

15 MR. INGLE: Nothing at all, sir.

16 THE COMMISSIONER: If he thinks there is  
17 something wrong.

18 MR. INGLE: I am not criticizing that at  
19 all. I think that is perfectly proper. Similarly, I  
20 think that employers under Schedule 1 might do the same  
21 thing. My only point in referring to that at all is that  
22 the employers under Schedule 2 do in fact, because the  
23 liability is so direct, contest these things far more  
24 vigorously than the employers under the other schedule. I  
25 am not suggesting there is anything improper about it, but  
26 the result of doing this is what I propose to come to next.

27 THE COMMISSIONER: Maybe the employers  
28 under the other schedule should protest more.

29 MR. INGLE: Perhaps so, but if that were  
30 done the inequities would be reduced, it is true, but I





1 suggest to the disadvantage of both the employer and the  
2 employee.

3 As I say, even though there may be no  
4 difference between the compensation an injured employee  
5 receives under Schedule 2 and the amount he might have  
6 received had his employer been under Schedule 1, there  
7 are inequities in the maintenance of the two separate  
8 schedules.

9 (1) Because of the greater tendency on the  
10 part of Schedule 2 employers to contest claims, there  
11 is inevitably greater delay in the payment of those  
12 claims and injured workmen thus suffer a hardship which  
13 they would not suffer if their employers were part of  
14 the collective liability system.

15 (2) The greater proportion of contested  
16 claims under Schedule 2 also means that the Board's  
17 administrative costs for Schedule 2 employers must be  
18 considerably higher than for Schedule 1 employers. Total  
19 costs of administration of the Board are, however, pro-  
20 rated equally among all employers with the result that  
21 Schedule 1 employers are paying part of the higher  
22 administrative costs occasioned by Schedule 2 employers  
23 contesting a higher proportion of the claims.

24 THE COMMISSIONER: This was all based  
25 upon your supposition, in any event; you have no figures  
26 that show that there are more contested claims under  
27 Schedule 2?

28 MR. INGLE: That is correct, sir, and if  
29 that is not the case, then my proposition in this respect  
30 falls, but I would suggest that the Board can verify this





1 very readily.

2 THE COMMISSIONER: I am just trying to  
3 recall whether it has been given in evidence here or  
4 whether it is personal information that was given in  
5 evidence by a member of the Board that while they have no  
6 specific figures it is not their impression that there  
7 are any more claims being contested under Schedule 2 than  
8 there are under Schedule 1.

9 MR. INGLE: I stand to be corrected on  
10 this. In my discussions with some members of the Board  
11 staff I had the impression there was a considerably  
12 higher proportion of claims under Schedule 2 contested  
13 than in the case of Schedule 1.

14 THE COMMISSIONER: There may be an  
15 argument for doing away with Schedule 2 anyway.

16 MR. INGLE: Despite that for one of the  
17 reasons that I now turn to.

18 In dismissing a request for the  
19 abolition of Schedule 2, Mr. Justice Roach stated at p.  
20 84 of his report, that:

21 "There is no danger that any of  
22 the industries in Schedule 2 would  
23 be financially ruined by accidents  
24 happening to their employees."

25 It is submitted, with great respect, that the learned  
26 Commissioner was in error. It is not at all inconceivable  
27 that a single accident, involving death and serious  
28 injury for a large number of workmen could cost  
29 hundreds of thousands and even millions of dollars in  
30 compensation and medical aid --- costs far beyond the







1 resources of many local municipalities, public utility  
2 commissions, police commissions, ferry boat operators,  
3 etc. And I cite two examples in this connection that I  
4 am informed occurred during the 1930's.

5  
6 The first was a tugboat belonging to a  
7 small navigation company on Lake Temagami which capsized  
8 with the resulting death of some five people. The company  
9 went bankrupt. They were under Schedule 2 and they could  
10 not meet the Workmen's Compensation claims.

11 THE COMMISSIONER: That was in what year?

12 MR. INGLE: I am not certain of the  
13 year. This information I can obtain, but it was during  
14 the 1930's. There was, of course, no authority for the  
15 Board to make any payment out of the funds in Schedule 1  
16 and it is my information that our national railways paid  
17 the compensation due in order to protect the separation  
18 of Schedule 2.  
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L/SS 1 A similar incident occurred around the  
2 same time, also in the thirties --- and again I can get  
3 this information and give it to the Commission --- in  
4 connection with a lake freighter in the Welland Canal.  
5 A man was crushed to death in an accident. The following  
6 year the company went bankrupt, they couldn't meet the  
7 compensation claims, and again the railways came to the  
8 rescue.

9 I may say that both these cases were  
10 the subject matter of a brief presented some years ago  
11 to the provincial government by the Railway Running Trades  
12 in argument for the elimination of Schedule 2.

13 Mr. Justice Roach himself, at pp. 110  
14 and 111 of his report (in dealing with the Investment  
15 Authority of the Board), refused to recommend authority  
16 for the Board to invest in debentures issued by municipal  
17 corporations in Ontario, drawing attention to the losses  
18 that had been incurred by the Board during the  
19 depression by reason of certain Ontario municipalities  
20 defaulting on their bonds! It is my submission that  
21 if there is a danger of a municipality or any employer  
22 under Schedule 2 defaulting on their bonds, then surely  
23 there is also a danger of its inability to meet  
24 compensation claims

25 The Commission's attention is drawn to  
26 the fact that other provinces operate their systems of  
27 Workmen's Compensation without the same division of  
28 employers into two categories as Ontario. There is no  
29 separate schedule for such employers in B. C., for  
30 example. Certain of the employers, including the railways





1 and Crown in right of the Province, are in separate  
2 classes for rating purposes but the principle of  
3 collective liability is extended to all without distinction.  
4 I note that in reading the report of Mr. Justice Tysoe  
5 the C. N. R. in British Columbia made representations  
6 to him for a special rating assessment so that they could  
7 avoid paying a portion of the reserves.

8 Manitoba and Saskatchewan have similar  
9 provisions. In the Alberta Act, schedule 2 covers  
10 employment by the federal and provincial governments and  
11 the Alberta Government Telephones, Section 63 (2) of the  
12 Act relieving such employers from contributing to the  
13 reserves under the Act. It does not, however, relieve  
14 such employers from collective liability for injuries.

15 It is submitted that the direct  
16 liability of the employers covered by Schedule 2 of the  
17 Act is contrary to the insurance principle underlying the  
18 Act. Mr. Justice Middleton, in warning of the dangers of  
19 a system of merit rating, said:

20 "...the whole principle of  
21 collective liability is based upon  
22 the doctrine of average. It is not  
23 enough that for a year, or even a  
24 short series of years, a particular  
25 factory escapes having any serious  
26 accident. The whole principle is  
27 that the fortunate must bear some  
28 portion of the burden of the  
29 unfortunate."

30 This argument is just as applicable to the abolition of







1 Schedule 2 as it is with respect to merit rating.

2 I turn now to the question of appeals and  
3 the new appeal procedure which was instituted by the  
4 Board in March, 1965.

5  
6 APPEALS

7 In March, 1965, new procedures were  
8 instituted by the Board for the review and handling of  
9 appeals. There, in our opinion, is now a great deal  
10 more formality in the review of cases and a more  
11 unsatisfactory procedure so far as appeals are concerned.

12 Prior to March, 1965, claims officers  
13 reviewed cases as they came in. If the claim was  
14 allowed, there was no problem. If there was incomplete  
15 information or if the officer had doubts about the  
16 circumstances of the accident, he took steps himself to  
17 obtain the information or resolve the doubt, either by  
18 letter or, in many cases, directly by telephone. In  
19 some cases he requested a local investigation by a  
20 member of the Board's staff. If there was insufficient  
21 medical information, or there was some doubt about  
22 medical aspects of the claim, he would request further  
23 medical opinion and if a difference of medical opinion  
24 existed, the matter would be referred to a medical referee  
25 under the provisions of Section 23.

26 If, after completing the above  
27 procedures, it was felt that the claim should be refused,  
28 it was reviewed by a committee of three senior claims  
29 specialists and any further action required to settle the  
30 question of entitlement was referred to a claims adjudicating





1 officer to be carried out. A notice was sent to the man,  
2 indicating that his claim had been refused and whether  
3 it was for medical or non-medical reasons. The claimant  
4 could then write to the Board and have a review made by  
5 the Review Board. There was a further appeal to the  
6 Workmen's Compensation Board itself.

7 At all times there was informal direct  
8 access to the Board and its staff for the man or any  
9 representative who endeavoured to assist him in the case.  
10 Union representatives, particularly, were able to obtain  
11 information from the Board, informally, and thus either  
12 explain to the man in layman's terms why it was felt  
13 that there was no point in pursuing his claim further or  
14 assist him in the preparation of his case for  
15 consideration by the Review Board or by the Board itself.  
16 The Board's staff were very helpful in providing assis-  
17 tance in the presentation of such cases.

18 THE COMMISSIONER: Are you not able to  
19 get that cooperation today?

20 MR. INGLE: No. It is our impression  
21 that the whole procedure now is much more formalized.  
22 This ready liaison which previously existed is not now  
23 the situation.

24 THE COMMISSIONER: You are obviously  
25 conscious of the fact that the increase in claims over the  
26 period has been very great and that they are now having  
27 to process numerous claims every day, I think over 1,000  
28 claims every day.

29 MR. INGLE: I appreciate this, but I  
30 think the phenomenon I am talking about is not attributable





1 to that fact, but it is attributable to the new formality  
2 of the new procedure.

3 THE COMMISSIONER: There is not only  
4 formality; you are suggesting, I suppose, that there is  
5 a tendency to be too impersonal and official about it  
6 all.

7 MR. INGLE: Exactly. I couldn't state it  
8 better, sir. That is precisely the case.

9 THE COMMISSIONER: It is pretty hard  
10 to get these things rolling with the organizations  
11 becoming larger and the necessity for dealing with them,  
12 to stay on the basis which was a desirable one previously,  
13 to keep away from formalities. It is forgetting about  
14 the individual, I suppose.

15 MR. INGLE: Yes, sir, that is one of the  
16 dangers of some of our more important institutions, and I  
17 suppose The Workmen's Compensation Board is no exception.  
18 I appreciate that. But it seems to me that the procedure  
19 which existed before ---- and previous to this time the  
20 Board was still dealing with a very large number of  
21 claims, and I think again that the cooperation which the  
22 officers and representatives of our union received from  
23 the Board's Staff was excellent, in view of the number of  
24 claims they had to deal with. Nevertheless, we still had  
25 this excellent cooperation, and it is our impression now  
26 that it is not the same.

27 THE COMMISSIONER: I would like to have  
28 something a little more particular about this, if there  
29 are some examples where you are being refused information  
30 or cooperation.







1 MR. INGLE: I would like to ask Mr.  
2 Dowling to answer that.

3 THE COMMISSIONER: Thank you.

4 MR. DOWLING: I have had relations  
5 representing this union for about 25 years with the  
6 Workmen's Compensation Board. I have handled several  
7 thousand claims with the Board. I had also a claim at  
8 one time prior to that. We had splendid relations with  
9 the Board in regard to claims, and it was not unusual that  
10 a member of our union or other unions or a worker  
11 requested assistance to establish entitlement under the  
12 Act. Normally he writes to the Claims Department, and  
13 if the information was wanted a telephone call would  
14 bring that information to us after one of the Board  
15 officers examined the file. Similarly, if the claim was  
16 rejected we appeared before a Review Board which had the  
17 right to make a decision, and at that level we sat just  
18 as we are sitting in this room, the company representa-  
19 tives were there, we could shake hands across the table,  
20 and the Chairman was at the same level. At the present  
21 time this has been changed and substituted for it from  
22 the first decision when you filed your claim for  
23 compensation or entitlement. We now have this setup  
24 known as a tribunal. It is not known as a Review Board,  
25 it is known as a Review Committee, which has powers to  
26 send out investigators, and so on; and even the change  
27 to the appeals tribunal is a delay. I have a form which  
28 has been printed in our office for years in which we could  
29 always list the details, the date, the claim number, the  
30 claimant. We have submitted as many as 20, 30, 35 of





1 these individual claims to a representative of the  
2 --- I can name the representative of the Board --- and we  
3 could have the files and we would have the names and I  
4 could report back to the worker if it should be processed  
5 further or not. There were several men known as assistants  
6 to the vice-chairman, there were four or five of them,  
7 and a telephone call or a letter to any one of these men  
8 would set up a schedule, and all this has been changed.  
9 I cannot meet with these men on the same basis on which I  
10 met with them up to before the tribunal was established.  
11 They are not known as assistants to the vice-chairman;  
12 their titles are Administrative Assistants. I have not  
13 been known as a counsel or applicant for the appellant,  
14 but we have not had the advantage or the justice. I  
15 mentioned that in 1948, and it is on the record, before  
16 Charles Baillie, the Minister of Labour. We appreciated  
17 we had that cooperation that is no longer in existence.

18 THE COMMISSIONER: The representations  
19 to the present Review Board are all in writing; is that  
20 it?

21 MR. DOWLING: That is right.

22 THE COMMISSIONER: And the first time  
23 you have an opportunity of appearing is on an appeal from  
24 the Review Board?

25 MR. DOWLING: I sometimes get them even  
26 from the first hearing or actually when the man makes his  
27 application for entitlement under the Act.

28 THE COMMISSIONER: Do you go in and  
29 discuss his claim?

30 MR. DOWLING: No, I do not; I do not have





1 that facility, and I have known some members of the Board  
2 for the last 25 years. It is the same men who put on  
3 educational programs, who speak at seminars, who appear  
4 with an information kit and explain the Act to them. They  
5 are men who know our union representatives personally.  
6 They are no longer available to us, which was accepted by  
7 ourselves, to deal with workingmen's problems under the  
8 Act. It no longer exists.

9 THE COMMISSIONER: What is the net result  
10 Are you having more claims turned down than you had  
11 before?

12 MR. DOWLING: We are not only having  
13 more claims turned down, but the facts we get back from  
14 the Board is a stock letter indicating that such and such  
15 a thing has developed and it is refused or it is reduced  
16 to 25%, whatever the case may be, or "the indications are  
17 you can return to light work". The Board has knowledge  
18 of these cases. It is because of these delays. We have  
19 in our collective agreements procedures to deal with it,  
20 and when the man wrote into the Board, to present  
21 evidence if he so wanted, if he wanted to appear before  
22 the Review Board he could, and from there he went to the  
23 top Board, and at that time it was dealt with in three  
24 weeks. Now I doubt if you can get a hearing from the  
25 committee to the tribunal under two months, and even when  
26 that evidence has been presented ---- and I know Mr. Ingle  
27 is going to follow this up ---- the fact is that these  
28 delays are destroying the confidence we had in the Board  
29 for a long number of years. There are nine men on the  
30 Review Committee or Review Board now. It was a fact that







1 we sat on an equal basis on the floor. Now with the  
2 tribunal sitting up high it almost looks like a court  
3 procedure, whether we are discussing arbitration cases  
4 agreement leading to arbitration, or even a conciliation  
5 board. These are the things our people are objecting  
6 If you ask for information on it now you get a summary  
7 on it by a Board officer.

8 THE COMMISSIONER: Thank you very much.

9 MR. INGLE: One supplement to what Mr.  
10 Dowling has said I would like to add with respect to the  
11 new procedure. Under the new procedure a claims  
12 adjudication officer must make his decision without the  
13 medical or non-medical information. There is an appeal.  
14 he goes on appeal to the Review Committee and then on  
15 appeal to the Appeal Tribunal, and then he has got to  
16 write in for a summary.

17 We had a case last week, where a man had  
18 an accident towards the end of September. He went to his  
19 general practitioner, a Dr. Jones, and on the basis of  
20 Dr. Jones' report a claim was made to the Board. After  
21 the claim had been submitted to the Board he went, on the  
22 29th of September, to a specialist, neural surgeon. On  
23 the 11th of October he was informed by the Board that his  
24 claim had been rejected. It was quite obvious that the  
25 Board had not yet received the specialists' report, because  
26 as of the 13th of October, last week, Dr. Jones had not  
27 received the report, and it was extremely unlikely that  
28 the Board had it on the 11th of October when the claim  
29 was rejected.

30 Now, it is our contention that the Board





1 should be free to look at that report when it comes in  
2 and revise their decision, rather than have the case  
3 go to the Review Committee. But under the new procedure  
4 the case is moved up from one step to another despite  
5 the availability of new evidence subsequent to the  
6 decision.

7 THE COMMISSIONER: I thought when the  
8 Board did this they were improving the situation. Instead  
9 of turning it down at the review stage, with only one  
10 appeal to the Board, he now has three bites to the  
11 cherry. That is the impression I had from looking at it,  
12 that they had two things in mind: one was the increased  
13 opportunities for appeal, and the other was to reduce  
14 the load on the members of the Board. It is obvious  
15 that they couldn't continue for long to take care of the  
16 increased volume.

17 MR. INGLE: With respect to that, sir,  
18 we have felt, and certainly other unions have felt, that  
19 with the new procedure we issued instructions to all  
20 our affiliated locals to appeal all cases. So if that  
21 is the object, they have not achieved it.

22 THE COMMISSIONER: Also I have seen some  
23 figures ---- I don't know if they are before us or not  
24 ---- which would indicate that quite a substantial  
25 proportion of appeals are allowed, first on the review  
26 level and then on appeal. Actually very few cases are  
27 turned down, about four per cent, something like that,  
28 in the end.

29 MR. INGLE: Under the previous  
30 procedure a lot of these cases would not have gone to





1 the formal Review Board at all, but would have been  
2 allowed at the committee stage.

3 THE COMMISSIONER: I judge that, from  
4 what Mr. Dowling says, it could have been sorted out at  
5 the lower level.

6 MR. INGLE: Yes.

7 THE COMMISSIONER: Would this matter be  
8 improved if Mr. Dowling had the opportunity of going in  
9 there before the appeal stage, having an opportunity,  
10 instead of having it done without representation, of  
11 going himself? If those facilities were available at  
12 that level, would that answer your problem?

13 MR. DOWLING: Not entirely. What we are  
14 anxious to do is to see that the proceedings are held in  
15 a more informal way; and there are some fair employers  
16 who will sit down and look at this thing. Now, under the  
17 system from the Claims Department to the Review Board,  
18 when I went before the Review Board, with either additional  
19 information or perhaps finding some errors in the  
20 decisions that have been made, I have had medical reports  
21 about a claimant having a back injury and he never had a  
22 back injury in his life, and I could look into that and  
23 the very same day a cheque went out. You are asking if  
24 that is the situation what will be available. I would say  
25 it would help, but again that other step of going to the  
26 tribunal is nothing but a delay. I doubt very much if  
27 I had a claim go from the review committee to the  
28 tribunal within two months, but yet I could get a  
29 hearing at the top level from the Review Board in two  
30 weeks before.







1 THE COMMISSIONER: If the same volume  
2 were existing today I don't see how it could be done in  
3 less than two months. I am not questioning what you  
4 say --- and we will get an explanation from the Board to  
5 tell us what that situation is --- but it is hard for me  
6 to believe ----

7 MR. DOWLING: I had a statement written  
8 down to check the application prior to the tribunal and  
9 after the tribunal and see how many days have gone by.  
10 Now, British Columbia has that, and I have their figures  
11 here of 23 days from the Claims Department to when it was  
12 finally adjudicated. I doubt very much if the Ontario  
13 section covers it on that basis.

14 THE COMMISSIONER: You can get it as to  
15 how long it took to get an adjudication at the basic level,  
16 the first adjudication, but then, I suppose, it varies  
17 from there on. Do you take an average of all claims?

18 MR. DOWLING: I understand this was all  
19 claims. British Columbia, I understand, was 23 days.

20 THE COMMISSIONER: The average was 23  
21 days. Is that what you say?

22 MR. DOWLING: In British Columbia it is  
23 23 days, if an examination could be held, say, in a year  
24 prior to the establishment of the tribunal, from the  
25 Claims Department to the top Board. I saw a similar  
26 comparison from the Claims Department to the top Board  
27 also included in that Appeals Tribunal, and I think you  
28 will find quite a discrepancy of time. Time is very  
29 important when there is nothing coming into a family,  
30 when compensation is not allowed entitlement, when it





1 runs into four, five, six, seven weeks and as high as  
2 three months.

3 THE COMMISSIONER: When was the tribunal  
4 established?

5 MR. INGLE: March, 1965, sir.

6 THE COMMISSIONER: March, 1965?

7 MR. INGLE: Yes. I don't intend to dwell  
8 on the unsatisfactory character of the summaries of  
9 medical evidence which are now in use. These are  
10 contained in the brief. I am not going to read them.

11 I will turn to the question of the  
12 scales of compensation, page 12.

13 SCALES OF COMPENSATION

14 It is our respectful submission that the  
15 rates of benefits under the Act, both to the injured  
16 workman in case of injury and to his survivors in case  
17 of death, are too low and should be increased. We feel  
18 that this is true with respect to the restriction of  
19 compensation to 75 per cent of earnings under Sections  
20 40 and 42 for total disability and to the 75 per cent of  
21 the loss of earnings under Section 41 for partial dis-  
22 ability. The fixed monthly payments to widows and children,  
23 the lump sum payments to widows and foster mothers, as  
24 well as the sum payable for burial expenses under Section  
25 37 are far too low. The \$6,000 limitation to be used in  
26 the calculation of average annual earnings for the  
27 purpose of determining rates of compensation should be  
28 removed. Each of these matters is dealt with separately  
29 below.

30 We submit that the 75 per cent rate, even





1 after the increase from 66-2/3 percent some years ago, is  
2 still too low and should be increased to 85 percent.

3 (a) Raising Restriction on Compensation from 75 percent  
4 to 85 percent of Earnings

5 When the Act came into effect on January  
6 1, 1915, the maximum rate of compensation was 55 percent  
7 of earnings. Five years later, in 1920, this was increased  
8 to 66-2/3 percent and this rate was maintained by all  
9 Canadian provinces for nearly 25 years. All suggestions  
10 that any higher percentage should be paid were met with  
11 the objection that any higher rate would lead to wide-  
12 spread malingering and fraud by employees trying to  
13 magnify the extent of their injuries so as to remain on  
14 compensation and avoid returning to work. However, when  
15 one province increased the percentage to 75 percent  
16 without any noticeable increase in malingering, other  
17 provinces, including Ontario in 1950, followed suit until  
18 the 75 percent rate became common to all ten provinces  
19 and to the Yukon and Northwest Territories.  
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1 It is submitted that the 75 percent rate  
2 is still too low and should be increased to 85 percent  
3 of earnings. There is no reason why a workman, injured  
4 in the course of his employment, should not be more  
5 fully compensated for his loss of income. To penalize  
6 the vast majority of injured workmen, by denying them  
7 adequate compensation because of the danger of malingering  
8 on the part of a small minority, is grossly unjust.  
9 In schemes for the payment of welfare and social assistance,  
10 there is sometimes the danger that a small minority,  
11 may abuse them. But that is no reason for denying  
12 adequate assistance to the majority. Most employees  
13 would prefer to know that they were earning their own  
14 way than that they were living on compensation to which  
15 their physical condition did not entitle them.

16 Because the workman, who is receiving a  
17 total disability pension, is relieved of payments for  
18 income tax, unemployment insurance and transportation  
19 to and from work, it is recognized that compensation  
20 payments do not have to be 100 percent of earnings in  
21 order to compensate him fully for his loss of earnings.  
22 It is submitted, however, that he is more nearly fully  
23 compensated if he is paid 85 percent rather than 75 percent.  
24

25 In his report, Mr. Justice Roach, at pp.  
26 27 and 28, dismissed the suggestion that the percentage  
27 of compensation, whatever it might be, should be applied  
28 to the net earnings of the workmen (i.e. after deducting  
29 income tax, etc.) instead of to the gross earnings. He  
30 cited two 1946 decisions in support of his contention  
that in the assessment of damages for loss of earnings,





1 no deductions should be made in respect of income tax  
2 or unemployment insurance premiums for which the plain-  
3 tiff would have been liable had he been able to continue  
4 in employment.

5 However, in judging the proportion of  
6 earnings on which compensation should be based, the  
7 argument persists that such items should be taken into  
8 account in order to ensure that the workman on compensa-  
9 tion does not receive more than he would have received  
10 had he remained at work. (See briefs of Ontario Forest  
11 Industries Association, pp. 4 and 5; Retail Council of  
12 Canada, para. 8, and Ontario Mining Association, sec.2).

13 Moreover, it has been held in an English  
14 case, subsequent to those cited by Mr. Justice Roach,  
15 (British Transport Commission v. Gourley (1956) A.C.  
16 185) that in assessing damages for loss of earnings,  
17 a deduction must be made on account of the income tax  
18 which has been, or will be saved upon those earnings.  
19 Incidentally, the learned author of the second edition  
20 of Munkman on Damages for Personal injuries states  
21 (p. 58) that:

22 "On the other hand, under the authorities  
23 as they stand at present, which appear to  
24 be consistent with Gourley's case, no  
25 deduction must be made for pensions or  
26 for money received under an accident  
27 policy, or for charitable assistance  
28 received either from relatives or from  
29 the general public."

30 This latter comment is drawn to the  
Commission's attention, in view of the suggestion made







1 in several briefs (e.g. that of the Retail Council of  
2 Canada, para. 9), that benefits to be made under The  
3 Canada Pension Plan should be taken into account in  
4 determining levels of payment under the Workmen's Com-  
5 pensation Acts.

6 For the above reasons, the following  
7 comparisons of compensation payments, as compared with  
8 "net earnings", are cited for the assistance of the  
9 Commission in this matter. The examples cited are  
10 similar to those referred to by Mr. Justice Roach,  
11 except that present levels of income tax, unemployment  
12 insurance and transportation are used rather than those  
13 in effect at the time of his report.

14 I do not intend to read these. The  
15 Commission may take a look at them at their convenience.  
16 I would like to make one comment here in connection with  
17 the brief submitted by the International Nickel Company  
18 where a similar calculation was made on page 12 of their  
19 brief and the statement was made that **taking** the  
20 case of a single man employed by this company earning  
21 \$100.00 a week who, as a result of an accident, receives  
22 compensation for temporary total disability and pointed  
23 out, or stated, that the whole amount of the \$75.00  
24 which he received would be received by him without  
25 deductions, whereas if he were working, they have listed  
26 a number of deductions that would be, so that his net  
27 income would be only \$77.16. The only point I want to  
28 make in this connection is that some of the items that  
29 are listed therein, it is true, would be deducted from  
30 the man who was employed and not be payable by the man







1 who was on compensation, but that is not true with  
2 respect to all of the items listed.

3 For example, the PSI which the man  
4 receives would have to be paid by the man himself if he  
5 wished to continue coverage and, indeed, after a man  
6 goes on compensation at the International Nickel Company,  
7 I think it is after a couple of weeks, he receives a  
8 bonus as follows from the International Nickel Company:

9 "Your Physician Services Incorporated  
10 premium must be paid each month. If this  
11 premium is not paid, your coverage will  
12 be cancelled and you will then be without  
13 coverage until such time as you can re-  
14 apply to have it reopened. Please for-  
15 ward payment of the premium listed below  
16 to the International Nickel Company of  
17 Canada, Limited at our office immediately.  
18 The premium for the month of (and then  
19 there is a statement coverage from July  
20 15th to August 14th, 1966<sup>is</sup> / \$5.30."

21 So that the impression given in Inco's  
22 brief that this kind of sum would not be payable by the  
23 man on compensation is not correct.

24 The same thing is true with respect to  
25 payment in respect of the Canada Pension Plan. It is  
26 true if a man goes on compensation, he doesn't have to  
27 make a contribution to the Canada Pension Plan but, by  
28 the same token, his coverage for that period is reduced  
29 and he gets no credit in the Plan itself. If he wants  
30 to have the period he is on compensation covered under





1 the Canada Pension Plan, he then has to make that  
2 additional payment.

3 As I believe the examples I have cited  
4 in the brief show, an injured workman receiving compensa-  
5 tion even at 85 percent of his average earnings will still  
6 not be in as good a financial position as he would have  
7 been had he continued at his employment, even after  
8 making allowance for income tax, unemployment insurance  
9 and transportation to and from work. He would, however,  
10 be much more equitably compensated than under the present  
11 rates and it is therefore recommended that the maximum  
12 rate of compensation be increased from 75 percent to  
13 85 percent.

14 I turn to the question of increasing  
15 pensions to disabled workmen and their survivors.

16 THE COMMISSIONER: I think we will adjourn  
17 for ten minutes.

18 ---Short recess.

19  
20 MR. INGLE: I was about to start on the  
21 section of our brief dealing with Increasing Pensions.

22 It is respectfully recommended that a  
23 provision be made in the Act to increase the rate of  
24 pension to disabled workmen and their survivors in  
25 accordance with increases in the cost of living. It is  
26 a well established fact that there is long-term general  
27 decline in the value of money. This is reflected in and  
28 may be measured by the increase in the cost of living.  
29 If a scale of compensation is adopted today, which is  
30 equitable in relation to the present value of the  
workman's loss of earnings, it will not be equitable 10





1 years hence because of this phenomenon. For example, a  
2 person awarded a monthly pension of \$100 in January 1956  
3 would find his pension reduced in real terms in January  
4 1966 to \$82.71.

5 In order to remedy this situation, British  
6 Columbia has recently accepted a recommendation of the  
7 Tysoe Commission to incorporate a cost of living formula  
8 in permanent disability awards. Under a new section of  
9 the B.C. Act, I believe it is Section 22A, for each  
10 rise of 2 percent in the Consumer Price Index, pensions  
11 to disabled workmen, dependent widows, invalid widowers  
12 and all allowances to dependent children are to be  
13 increased by 2 percent and adjustments under this  
14 formula are to be reviewed annually. It is recommended  
15 that your Commission give favourable consideration to  
16 the adoption of a similar formula in Ontario.

17 THE COMMISSIONER: Do you know of any  
18 other jurisdictions in the States or elsewhere where  
19 that has been adopted?

20 MR. INGLE: No, I am unaware. I may say  
21 the fact that I am not aware of anything in the States  
22 or in other jurisdictions doesn't mean anything, because  
23 I haven't looked at them all.

24 It should be noted, so far as cost to  
25 the employer is concerned, that the lack of any pro-  
26 vision hitherto to relate pensions to the increased cost  
27 of living has operated in the employer's favour.  
28 The pension award, which cost him \$100 in January, 1956,  
29 cost him only \$82.71 in January, 1966. The employer  
30 has enjoyed decreasing compensation costs as the value







1 of money steadily declines.

2 THE COMMISSIONER: That statement refers  
3 to the included value of money, is that right?

4 MR. INGLE: That is right.

5 THE COMMISSIONER: \$100.00 pension in  
6 1956 recommended \$82.71 in 1966?

7 MR. INGLE: That is exactly right. Just  
8 as the value to the workman of that pension has declined  
9 so the cost to the employer has declined and he has had  
10 the advantage of the declining value of the dollar just  
11 as the workman has suffered that disadvantage.

12 It is noted that briefs submitted on  
13 behalf of some employers have contained complaints that  
14 the retroactive effect of periodic increases in com-  
15 pensation rates have been unfair. It is suggested,  
16 however, that such periodic increases even when they  
17 are retroactive, are more than compensated for by the  
18 phenomenon referred to above.

19 THE COMMISSIONER: Well, you are talking  
20 about two different things. One is the provision for  
21 the future; should the provision be such as to apply  
22 for some calculated increase in the cost of living,  
23 that is on pensions that are received from this day  
24 forward.

25 MR. INGLE: Yes.

26 THE COMMISSIONER: Now, insofar as  
27 pension costs are concerned, that has been discussed  
28 on a good many occasions before a good many Commission  
29 It may be on a different basis of when you come  
30 to ask today's industry to pay for what was an





1 obligation of yesterday's industry, and there Mr. Justice  
2 Roach and others felt that while it was desirable  
3 it was more the obligation of the Province not having  
4 been provided for in the past, it became more an obliga-  
5 tion of the past than it was of the industry?

6 MR. INGLE: With respect, sir, I suggest  
7 they are not unrelated. It is true that the retroactive  
8 effect of any pension increase which may be granted,  
9 sir, as a result of this Commission's recommendations  
10 would mean an additional cost to present-day employers  
11 over and above the costs they would have had, and this  
12 may seem to be inequitable. All I am suggesting here  
13 sir, is that in my opinion it is more than made up for  
14 by this advantage which they have had from the decreasing  
15 value of money.

16 THE COMMISSIONER: But today's employer  
17 might not have had that advantage. Maybe the man,  
18 maybe the injury suffered was in some company that has  
19 gone out of business.

20 MR. INGLE: If the recommendation with  
21 respect to the cost of living increase is not accepted  
22 and some level of pensions is decided upon as a result  
23 of the recommendations of this Commission, then today's  
24 employers will enjoy for the next few years this  
25 advantage so far as the decreasing value of money is  
26 concerned, and this will more than make up to them  
27 any inequities so far as the obligations of the past  
28 compensation awards are concerned. At least, this is  
29 my submission, sir.

30 This is what I have dealt with on the





1 top of page 18. It has been suggested by some employer  
2 groups (see brief of Ontario Federation of Construction  
3 Associations, para. 2, pp. 3 and 4) that any additional  
4 costs of upgrading compensation benefits should be paid  
5 by government out of the Consolidated Revenue Fund. In  
6 view of the savings which employers make on compensation  
7 because of the decreasing value of money, as indicated  
8 above, it is suggested that it is not at all inequitable  
9 that the whole cost of increased compensation should be  
10 paid by employers. It seems to us that the total cost  
11 of reimbursing, so far as money can do so, employees  
12 for injuries arising out of their employment should be  
13 a cost borne by industry itself and not by the general  
14 public.

15 May we further point out, for the  
16 Commission's consideration, that the fixed level of  
17 pension for the permanently disabled takes no account  
18 of general increases in the level of productivity and  
19 of incomes in the community. Neither does it take into  
20 account the personal advances that would have been  
21 possible for the workman had he not been injured.  
22 Aside altogether from the decreasing value of his  
23 pension because of increases in the cost of living,  
24 as referred to above, there tends to be a gradual  
25 decline in the relative value of his pension for these  
26 reasons.

27 It is noted that a number of briefs,  
28 submitted to your Commission on behalf of employers and  
29 employer groups, have urged that payments, under the  
30 Workmen's Compensation Act, should be no substitute for







1 social welfare (see brief of Ontario Division The  
2 Canadian Manufacturers' Association, paras. 6 to 8, 19  
3 to 21 and 26; CNR-CPR brief p. 6 and Construction  
4 Association's brief, para. 2). It has been contended  
5 that the costs of increased benefits in respect of past  
6 injuries and cost of full compensation for temporary  
7 partial disability, where suitable light work is not  
8 available, should be treated as social welfare and not  
9 be paid by Workmen's Compensation funds.

10 It is respectfully submitted that such  
11 contentions are not valid. The total cost of fully  
12 compensating a workman for injuries suffered during  
13 employment is properly chargeable to the industry con-  
14 cerned. It is noted with interest, that the very  
15 same briefs which contend that Workmen's Compensation  
16 funds are not to be used to meet the so-called "social  
17 welfare" costs referred to above, have no hesitation  
18 in suggesting that social welfare schemes, such as  
19 OMSIP and the Canada Pension Plan should operate to  
20 reduce the liability of employers to pay full compensa-  
21 tion (see submission of Ontario Division The Canadian  
22 Manufacturers' Association, para. 33 and brief of Con-  
23 struction Associations, paras. 7 and 8 and Automotive  
24 Transport).

25 (c) Temporary Partial Disability

26 Under Section 41 of the Act, the compensa-  
27 tion payable in the event of temporary partial disability  
28 is 75 percent of the difference between the actual  
29 average weekly earnings earned by the workman before the  
30 accident and "the average amount that he is earning or





1 is physically capable of earning, as determined by the  
2 Board, in some suitable employment or business, after  
3 the accident....". The medical examiner may report  
4 that an injured workman is not fully disabled but that  
5 his disability is only, say 50 percent, and that he  
6 therefore is capable of "light work". Unfortunately,  
7 his employer has no suitable light work available for  
8 him in which he can use his 50 percent capability. He  
9 is not eligible to receive any unemployment insurance,  
10 yet his compensation is rated at only 75 percent of 50  
11 percent of his former earnings. Thus an employee whose  
12 remuneration was \$100 per week but who is injured so  
13 that his physical capacity is reduced to 50 percent and  
14 who is unable, as a result of his injury, to obtain any  
15 employment of any kind, receives only \$37.50. It is  
16 submitted that in such cases, an employee should receive  
17 his full compensation so long as his employer is unable  
18 to give him employment commensurate with his physical  
19 abilities.

20 I may add that it is often hard enough  
21 to find work for a man who has had some of high school  
22 education or some special skill or mechanical training,  
23 but most often, it is the fellow who has none of these  
24 advantages but who only has his two hands to do his  
25 work. This kind of employee has little or no chance  
26 under Section 41 as it is now where there is no light  
27 work available. I may say that I am going to say some-  
28 thing further in respect to this matter, but I will deal  
29 with it when I am dealing with the brief of the Inter-  
30 national Nickel Company a little later.







1 It is noted that the basic principle  
2 underlining the Act is compensation to the injured  
3 employee for loss of earnings resulting from his injury.  
4 In Section 41, however, there is a serious deviation  
5 from this principle so that an injured workman is com-  
6 pensated not in relation to his loss of earnings but in  
7 relation to his degree of disability.

8 (d) Payments to Widows, Invalid Husbands, Foster  
9 Mothers and Children

10 At present the widow of a workman who  
11 has lost his life, as a result of an accident arising  
12 out of his employment, receives a monthly payment of  
13 \$75. If she has one or more dependent children, she  
14 receives an additional \$40 per month for each child. It  
15 is respectfully submitted that a widow with school or  
16 pre-school children cannot afford to pay for accommoda-  
17 tion alone out of such sums. She must, therefore, seek  
18 employment herself, which may be virtually impossible if  
19 one or more of her children are of pre-school age, or  
20 she must depend on public welfare or private charity.  
21 There is no excuse, we submit, sir, for the treatment,  
22 in this fashion, of the survivors of workmen who lose  
23 their lives as a result of their employment. There is  
24 absolutely no reason why the survivors should not be  
25 maintained in the station in life to which they had  
26 been accustomed, and the cost fully borne by the industry  
27 to which the husband and father has given his life.

28 With that end in view, it is respectfully  
29 submitted that compensation payments to surviving  
30 dependents of workmen who lose their lives in industrial







1 accidents bear a relationship to the employees' earnings.

2 We respectfully request that the Comm=  
3 ission recommend that a widow (or invalid husband, as  
4 the case may be) should receive compensation at the rate  
5 of 75 percent of the employee's earnings or a minimum of  
6 \$100. per month so long as there is no re-marriage.

7 Allowances for dependent children should be increased  
8 proportionately.

9 Where dependent children continue to  
10 attend school or other educational institutions, benefits  
11 under the Act should be continued beyond the age of 16.

12 Now I am aware that in Section 37(2) of  
13 the Act, there is some provision for this, but I should  
14 like to read to you, Mr. Commissioner, the wording of  
15 that Section:

16 "Where, in the opinion of the Board, the  
17 furnishing of further or better educa=  
18 tion to a child appears advisable, the  
19 Board, in its discretion, may on applica=  
20 tion extend the period of compensation  
21 for such additional period as is spent  
22 by the child in furthering or bettering  
23 its education."

24 Very briefly, our submission is that this  
25 should not be a matter within the discretion or on the  
26 sufferance of the Board, but should be provided as of  
27 right where the child is in school or is continuing  
28 education.

29 THE COMMISSIONER: That is Section what?

30 MR. INGLE: That is Section 37(2) of





1 the present Act. I think it was just amended last year,  
2 if I am not mistaken.

3 The Commission's attention is drawn to  
4 the fact that payments to the surviving widow, or  
5 invalid widower, are \$85 per month in Alberta, \$115 per  
6 month in British Columbia, \$90 per month in Nova Scotia,  
7 \$110 per month in Saskatchewan, \$90 per month in the  
8 Northwest Territories and \$100 per month in the Yukon.

9 I should, perhaps, qualify that in respect  
10 of Saskatchewan. In that Province, the \$110 is payable  
11 to age 70 and then is reduced to \$75. Payments to  
12 dependent children are \$45 per month in Alberta and  
13 Saskatchewan. Provision is made, in British Columbia,  
14 New Brunswick, Quebec and the Yukon, to continue payments  
15 for dependent children beyond the age of 16, where they  
16 are attending school. And I draw the Commission's  
17 attention to this additional fact, that in B.C. not only  
18 is there a provision for the continuing of such payments,  
19 but they increase as the child grows older. It is a  
20 \$40 payment up to the age of 16, where a child is with  
21 his parents, and that is increased to \$45 to the age  
22 of 18, \$50 to the age of 21 and, in the case of orphans,  
23 the payments are \$45 to age 16 and \$55 to age 21.

24 One additional point which I should like  
25 to make here which is not in the brief is that we should  
26 also like to recommend the removal of the \$150 limit  
27 on payments to dependents, which is contained in sub-  
28 sections (B) and (C) of Section 37(3) of the Ontario  
29 Act, so as to remove what we consider the inequities  
30 that now exist in respect of large families.





I turn to the question of Burial Expenses.

It is respectfully submitted that the present allowance contained in Section 37 (1) of a maximum of \$300 for necessary burial expenses is grossly inadequate. Enquiries made recently of several major funeral directors in the City of Toronto show the following basic charges:

<u>Name</u>	<u>Indigent or Pauper Funeral</u>	<u>Others*</u>
Jerrett Funeral Chapels Ltd.	\$250.00	\$400.00
Humphrey Funeral Home & Chapel Ltd.	250.00	\$395.00 - \$450.00
Wm. Speers Funeral Directors	200.00	(no quotation)
Turner & Porter Funeral Directors Ltd.	250.00	398.00 - 495.00
Earle Elliott Funeral Homes	240.00	397.00 - 495.00

\* - Prices vary according to caskets.  
(There is an extra charge for more than one family car).

I draw your attention, sir, to the fact that in light of the charges we have quoted and which are set forth in our brief, it will be observed that for the \$300.00 allowance made now under the Act, the family of a workman killed as a result of an accident arising out of his employment can obtain for him only what amounts to a pauper's funeral. The cost of a cemetery plot is over and above the costs referred to above. The minimum cost of such plots varies from \$75 up, and opening and closing the grave is an additional \$45 in the summer time, and \$55 in the winter time. I note that in Manitoba there is a specific extra allowance of \$50







1 in that Province for a burial plot. That is contained  
2 in Section 21 (1) (a) of the Manitoba Act. It will be  
3 seen that the basic cost of a modest funeral will run  
4 between \$500 and \$600. In addition to such basic costs  
5 there are, of course, the other miscellaneous costs  
6 such as wreaths, flowers, extra cars, newspaper notices,  
7 church services, gratuities for clergymen, etc, and,  
8 of course, a major one, a headstone for the grave. It  
9 is therefore recommended that the \$300 provided for  
10 burial expenses, Section 37 (1)(a) be increased to  
11 \$700.

12 I want to stop there, Mr. Commissioner,  
13 and add this: I recognize that there is simply, if our  
14 recommendation is accepted in this respect and the pro-  
15 vision in 37 (1)(a) simply increased to \$700., it may  
16 be that some abuse could creep into the Act because  
17 it is just possible that some unscrupulous funeral  
18 directors might increase their basic prices to the level  
19 set forth in the Act. Therefore, I suggest, sir, that  
20 if the Commission considers this recommendation favour-  
21 ably that they pay some regard to ways of avoiding abuse  
22 in this connection. The basic allowance, I may suggest,  
23 for burial expenses might be increased to, say, \$400.  
24 with a specific payment of \$75 for a plot, \$50 for  
25 opening the grave and a specific amount for a headstone  
26 and then an extra amount added, perhaps, to the lump  
27 sum payable to the widow so that she can meet the burial  
28 expenses which, as I say, we think run in the neighbour-  
29 hood of some \$700 for a modest funeral.

30 The Commission's attention is drawn to  
the fact that in the Province of Quebec, Section 34 (1)





1 of their Act provides an allowance of \$600 for funeral  
2 expenses in addition to the \$150 allowed for transporta-  
3 tion of the body and a \$300 lump sum payable to the widow.

4 Section 37 (1)(a) of the Ontario Act  
5 provides for the payment of a \$300 sum for the necessary  
6 expenses of burial only. It is recommended that payment  
7 be authorized for cremation as well. Where cremation,  
8 rather than burial is desired, the practise at present  
9 is for the Board to make payment on the same basis as  
10 for burial. We feel, however, that this should be  
11 specifically provided for in the Act and not be subject  
12 to the discretion of the Board. We may point out that  
13 section 18 (a) of the British Columbia Act authorizes  
14 payment for cremation as well as for burial.

15 The next section is a particularly  
16 important one, Mr. Commissioner, and that is our re-  
17 commendation that the \$6,000 limitation on earnings  
18 in Section 44 (1) be removed. Originally this maximum  
19 was fixed at \$2,000 and has been increased over the  
20 years. The precise reason for ~~fixing~~ such a maximum  
21 is not clear to us. Perhaps it was an attempt to dis-  
22 tinguish between "workmen" and other employees. The  
23 comments made by Mr. Justice Roach in his report at pp.  
24 25 and 26, where he deals with this question, imply as  
25 much.

26 If this is the purpose, the present pro-  
27 visions of the Act do not accomplish that purpose and  
28 the application to a limit to earnings, as provided in  
29 Section 44, does not distinguish between two groups of  
30 employees. The Act applies to all "workmen" and the





1 definition of "workmen" under Section 1 (1)(u) of the Act  
2 includes every person who works under a contract of  
3 service, whether by manual labour or otherwise, with  
4 the exception of an "executive officer of a corporation".  
5 There is no distinction based on earnings.

6 The only practical effect of the provision  
7 of Section 44 (1) is seriously to limit the compensation  
8 to which the more highly skilled and more highly paid  
9 employees may be entitled. Chief Justice Meredith, in a  
10 quotation, cited at p. 26 of Mr. Justice Roach's report,  
11 attempted to avoid any such restriction by stating that  
12 he had chosen the then recommended limitation of \$2,000  
13 per annum "because that sum is probably the maximum  
14 amount earned in a year by the highest paid wage earner".  
15 If a maximum is to be written into the Act (and it is our  
16 respectful contention that it should be removed altogether)  
17 then the \$6,000 limit in the present Act does not by any  
18 means represent the maximum amount earned in a year by the  
19 highest paid wage earner.

20 Under the recent collective agreement  
21 signed between the United Steelworkers of America and  
22 The Steel Company of Canada, a 1st helper on the 500 ton  
23 open hearth, in Hamilton, Job Class 28, at an hourly  
24 rate of \$4.589, plus 30 percent incentive earnings, would  
25 earn in the course of each year, without any overtime  
26 whatsoever the sum of \$12,729.60. Under a recently  
27 negotiated contract a journeyman plumber, in the City of  
28 Hamilton, making \$5.05 would earn in a course of a normal  
29 working year, without any overtime, the sum of \$10,504.

30 Average annual earnings based on average







1 weekly wages in the month of January, 1966, in six  
2 Ontario industries are shown in the following table:

3	Petroleum & Cola Products	\$7,177.04
4	Engineering (other than highways, bridges and streets)	6,412.12
5	Motor Vehicle Assembling	6,396.00
6	Agricultural Implements Manufacturing	6,228.04
7	Special Trade Contracting	6,115.08
8	Industrial Chemical Manufacturing	5,998.20
9	- (Man Hours and Hourly Earnings D.B.S. January, 1966, Table 6)	

11 These figures which I have quoted will  
12 indicate the kind of levels which are now being paid in  
13 certain cases to high skilled and high paid workers.  
14 I notice that on page 9 of the material which the  
15 Workmen's Compensation Board have prepared for this  
16 Hearing and I understand they have submitted that in  
17 1965, 18.2 percent of all those awarded temporary total  
18 disability compensation earned over \$6,000. and, in  
19 1966, according to a footnote on the table, 25.2 percent  
20 were over the \$6,000 maximum. These figures would seem  
21 to correspond with those in British Columbia. In Mr.  
22 Justice Tysoe's Report at page 34, he noted that in  
23 1963, 18.8 percent of all British Columbia workmen  
24 covered by compensation earned over \$6,000., and, un-  
25 doubtedly, it would be more today.

26 The inequity of the present limitation is  
27 readily apparent if one considers the position of one of  
28 the more highly paid employees, whether he is a wage  
29 earner or not. Suppose the superintendent of a plant,  
30 who is not "an executive officer of the corporation"





1 but whose annual income is \$20,000 per year, is permanently  
2 disabled through personal injury by an accident in the  
3 plant. He is entitled to compensation under the Act but  
4 the maximum he can receive is \$4,500 per year.

5 It is respectfully recommended that this  
6 limitation be eliminated from the Act, both in respect  
7 of Section 44 and Section 99.

#### 8 INDUSTRIAL DISEASES

9 When the Act first came into effect, in  
10 1915, only six diseases were named as Industrial Diseases.  
11 As the knowledge of industrial diseases has increased,  
12 other diseases have been added from time to time until  
13 Schedule 3 now contains a list of 15 broad headings of  
14 such diseases together with many sub-heads so as to  
15 cover poisoning and its sequelae by various substances,  
16 as well as various categories of pneumoconioses, diseases  
17 due to radioactive substances and different types of  
18 ulceration.

19 Experience in other provinces suggests  
20 that the present list of industrial diseases, set out in  
21 Schedule 3, is still inadequate. Indeed some of the  
22 recommendations for additional coverage made by Mr.  
23 Justice Roach, 16 years ago, have not yet been accepted -  
24 such as lung cancer, where the workman is employed in a  
25 process by which he is subjected to the inhalation of  
26 concentrated gases from coal, tar or pitch and silicosis  
27 in every process where the workman is subjected to the  
28 inhalation of silica dust created by the nature of the  
29 work performed by him or others.

30 The Board's present practice is to pay





1 compensation for many industrial diseases not now covered  
2 by Schedule 3 on the ground that they are "peculiar to  
3 or characteristic of a particular industrial process,  
4 trade or occupation." That is a quotation from Section  
5 1, Sub-section (1) (I) of the present Act. We feel that  
6 such a practice is inadequate. A person may incur a  
7 disease caused by conditions of his employment without  
8 being able to prove that the disease is "peculiar to or  
9 characteristic of" the particular occupation.

10 I note that Mr. Justice Tysoe, and this  
11 is dealt with at pages 229 and following of his Report,  
12 went into this matter in some detail there and he very  
13 severely criticized the tendency of the British Columbia  
14 Board, in spite of provisions in their Act similar to  
15 the ones that I have just quoted from Section (1) (1)(I)  
16 of our Act to disallow all claims for industrial disease  
17 which were not specifically covered in the schedule.

18 Now, I am not suggesting that the Board  
19 in Ontario does that; I have no knowledge, but I suggest  
20 that it is something enquiries might be directed to the  
21 Board about, similar to those which Mr. Justice Tysoe  
22 directed to the B.C. Board in this connection.

23 To the extent that specific diseases and  
24 processes associated with each are named in Schedule 3,  
25 any doubt or confusion will be eliminated.

26 Some of the diseases compensable in other  
27 provinces but not specifically covered in Ontario include  
28 the following:  
29  
30







Nethercut & Young  
Toronto, Ontario

1536

1	<u>Name of Disease</u>	<u>Description of Process</u>	<u>Province</u>
2	Occupational deafness	Any industry involving prolonged and continuous exposure to excessive noise	B.C.
3			
4	Asbestosis	Any industry or process where there is exposure to asbestos fibre	B.C., N.B. & Quebec
5			
6	Asthma & Respiratory irritations	Exposure to organic or fibrous dusts	B.C.
7			
8	Bovine Tuberculosis	Laboratory work or handling of animals	Sask.
9			
10	Undulant Fever	Laboratory work or handling of animals or carcasses	B.C., N.B., P.E.I., Quebec & Sask.
11			
12	Bronchitis & Pulmonary oedema	Any process using oxyacetylene or electric arc for cutting or welding	B.C.
13			
14	Circulatory disturbances of the extremities	Muscular effort at low temperatures or handling cold materials	B.C.
15			
16	Conjunctivitis	Exposure to dust, heat, gases, fumes, vapours, mists or smoke	B.C.
17			
18	Dermatitis	Any process involving contact with certain named substances	B.C., Alta. & Man.
19			
20	Formaldehyde poisoning	Any process involving the use of, or direct contact with formaldehyde and its preparations	B.C. & Sask.
21			
22	Salmonellosis	Employment in hospitals, sanatoria, etc.	B.C.
23			
24	Sir, we don't pretend to be experts or		
25	qualified to make specific detailed recommendations		
26	with respect to the addition of diseases to Schedule 3		
27	of the Ontario Act. I have simply listed on page 25		
28	of the brief some of the occupational diseases or		
29	industrial diseases which are covered in similar		
30	schedules in other provinces as being some indication of		





1 omissions or possible omissions from the Ontario Act.  
2 We are not in a position to judge, as I say, in most  
3 cases, whether a particular disease should be covered or  
4 should not. The criterion, however, if I may suggest  
5 it, it seems to me might be this, that if there was a  
6 particular disease where there there is a greater in-  
7 cidence of that disease among particular long employees  
8 of particular firms than there is among the general  
9 population, then it seems to me that there is reason for  
10 including it in the schedule of industrial diseases.

11 Mr. Justice Tysoe makes that recommenda-  
12 tion, I believe, at page 228 of his report. There is,  
13 however, one specific request for inclusion of our  
14 industrial disease in the Act and that is one that was  
15 made to you, sir, I understand, by The Ontario Profess-  
16 ional Fire.Fighters Association for a presumption in  
17 favour of fire fighters in respect of heart and lung  
18 disease. We suggest that this could be accomplished by  
19 the addition to Schedule 3 of "Injury to the lungs and  
20 heart when engaged in fire fighting." Incidentally,  
21 that specific addition was made to the B.C. Act on the  
22 14th of April, 1954. I now deal with Pre-Existing  
23 Physical Conditions. In dealing with this subject, at  
24 p. 46 of his report, Mr. Justice Roach said:

25 "Illustration: a workman suffering from  
26 diabetes may suffer a very minor injury to  
27 a toe due to a weight falling on it. His  
28 diabetic condition aggravates that injury  
29 and it becomes so serious that the whole  
30 foot has to be amputated.





1 "The Board informed me that in the case  
2 illustrated it would consider the loss  
3 of the foot as having been partly caused  
4 by the pre-existing diabetic condition  
5 and would award to the workman only fifty  
6 per cent of the amount which would normally  
7 be awarded to him for the loss of a foot.

8 "In my opinion such a policy is not  
9 authorized by the Act.

10  
11 "Section 2 (1) provides that compensation  
12 shall be awarded for injury caused by  
13 accident. In the case illustrated the  
14 loss of the foot was not caused by the  
15 diabetic condition within the meaning of  
16 those words in the section. It is true  
17 that without the previously existing  
18 diabetic condition the workman would not  
19 have lost his foot but the real and  
20 effective cause of the ultimate injury  
21 was the weight falling on the toe, and  
22 not the diabetic condition.

23 "All workmen are entitled to the full  
24 protection of the Act without any dis-  
25 crimination based on their physical con-  
26 dition."

27 He supported his position by reference to  
28 the well-known "thin skull" illustration and to two  
29 Court of Appeal cases in England. He recommended that  
30 the Act be amended to provide that where an accident







1 causes an injury aggravating some pre-existing physical  
2 condition, the workman should be compensated for the  
3 full injuries resulting. His recommendation has not  
4 been implemented and it is respectfully submitted that it  
5 should be.

6 The Honourable W.F.A. Turgeon, P.C., in  
7 his report on the Manitoba Act in 1958, spent some time  
8 on this problem and, at page 52 of his Report, he quoted  
9 in some detail from an American case, from Illinois I  
10 believe it was, in support of the rule that if a work-  
11 man's existing physical structure, whatever it may be,  
12 gives way under the stress of his usual labour, his  
13 death is an accident which arises out of his employment.

14 If the accident which aggravated his pre-  
15 existing condition had not occurred, he could have  
16 carried on indefinitely despite his condition. The  
17 accident has deprived him, therefore, of the opportunity  
18 to do so and, therefore, the accident should be charged  
19 with the full cost of the resulting injury.

20 MR. ESTEY: Did you read that from the  
21 Turgeon Report?

22 MR. INGLE: That is the Turgeon Report,  
23 Mr. Estey, at page 52.  
24  
25  
26  
27  
28  
29  
30





1 I would like to quote some words from  
2 Mr. Justice Tysoe's report at page 220. He said this:

3  
4 "If such (industrial) an injury  
5 converts a dormant condition which is  
6 non-disabling into an active one  
7 which is disabling, it seems to me that  
8 the injury should be regarded as the  
9 cause of the disability.

10 Certainly, in jurisdictions where  
11 recourse to the Courts in compensa-  
12 tion cases is available to workmen,  
13 it is well established that when  
14 industrial injury precipitates dis-  
15 ability from a latent or dormant  
16 prior condition, the entire dis-  
17 ability is compensable. The rule  
18 that is followed is that to be  
19 apportionable an impairment must  
20 have been independently producing  
21 some degree of disability before the  
22 occurrence of the industrial injury  
23 and must be continuing to operate  
24 as a source of disability after that  
25 occurrence. I regard this rule as  
26 a sound one and properly applicable  
27 in our compensation scheme." ---

28 referring to the compensation scheme of British Columbia,  
29 of course.

30 This matter, we suggest, is extremely





1 important because of the fact that very often the determi-  
2 nation by the Workmen's Compensation Board, as to whether  
3 an injury is caused by accident arising out of employment  
4 is based on medical opinion and because of the basically  
5 different approach between doctors and lawyers on this  
6 subject. This difference was the subject of a recent  
7 short article in the Canadian Bar Journal for August,  
8 1966, at p. 306 by Thomas O. Griffiths. Mr. Griffiths  
9 commented at p. 308 of the article as follows:

10 "CAUSE  
11

12 "In tort law the search is for  
13 the proximate cause of a resulting  
14 condition or effect. Thus, if as a  
15 result of an injury a latent condi-  
16 tion becomes a disability the injury  
17 at law is the cause, ie., the proxi-  
18 mate cause is virtually synonymous  
19 with the medical phrase 'precipitating  
20 factor' it is certainly not what the  
21 doctor means by the word 'cause'.

22 "To take a chemical analogy, if  
23 a test tube contained three re-agents  
24 and a fourth was added and an explo-  
25 sion resulted, to the tort lawyer the  
26 addition of the fourth re-agent  
27 and not the pre-existing re-agents  
28 would be the real or proximate cause  
29 of the explosion. However, to the  
30 physician it would be the three







1 pre-existing re-agents or etiology  
2 which would be the 'cause' of the  
3 explosion and the fourth re-agent  
4 would be merely the precipitating  
5 factor.

6 "OTHER CAUSES

7 "Similarly, once it has been  
8 established that the act of the  
9 wrongdoer" ---

10 in a negligence case, I presume ---

11 was the proximate cause of the  
12 damage or disability the 'thin  
13 skull rule' applies and it is no  
14 defence to argue that such damage  
15 or disability might have resulted  
16 later from contingencies other  
17 than the tortious act."

18 The attitude of the Board's doctors to this question was  
19 seen during the course of an address to a Workmen's  
20 Compensation SEminar, sponsored by the Ontario Federation  
21 of Labour in 1963, by Dr. M. G. Lester, who I understand  
22 is one of the Consultant Dermatologists of the Board (see  
23 report of Seminar at p. 26). Dr. Lester was dealing with  
24 the interplay between pre-existing skin diseases and  
25 occupational exposures. He mentioned the cases where  
26 persons were susceptible to exzema and the difficulty  
27 a medical officer had in trying to determine whether it  
28 was the occupational exposure which caused the resulting  
29 dermatitis or whether it was the pre-existing skin  
30 condition. He said "Because, at this point again, the





1 patient's own body is responsible, and therefore I feel  
2 rightfully that the Compensation Board should not be held  
3 responsible for this part of his skin problem". This is  
4 precisely, if I may say so, the attitude which Mr.  
5 Justice Roach and Mr. Griffiths in the article I have  
6 mentioned were referring to, and it is more than likely  
7 that Dr. Lester's view on the causes of injuries is not  
8 an isolated one, but I suggest it may be shared by other  
9 doctors on whose opinion the Board relies in determining  
10 whether or not a particular injury is compensable. I  
11 note that the brief of the Motor Vehicles Association, I  
12 believe it was, contends that awards for injuries where  
13 there are adverse pre-existing conditions should be paid  
14 by society rather than by industry. It seems to me that  
15 any such idea would introduce a very dangerous concept.  
16 You can just imagine the Board saying, "This man's bones  
17 were more brittle than that one and therefore he should  
18 get compensation, and in this case society should pay  
19 for it". This is a very dangerous concept, in my opinion,  
20 and is against what Mr. Justice Roach said. At page 18 of  
21 Mr. Justice Tysoe's report he says, "The prime mission" --  
22 --- I ask you, sir, to note that I emphasize "prime  
23 mission" --- "of those who administer workmen's  
24 compensation and the prime purpose of the Act is not to  
25 furnish financial benefits, but to promote and encourage  
26 measures for the prevention of injury to workmen in the  
27 course of their work...." Of course, he was talking  
28 about the British Columbia Act, which is substantially  
29 different from our Act in this respect and which I will  
30 note in a moment.





ACCIDENT PREVENTION

As Mr. Justice Roach stated at p. 91 of his report, "The prevention of accidents in industry is a subject of no less importance than is compensation for injuries sustained as a result of such accidents. It is infinitely more important that, where possible, an accident should be prevented than that it should be permitted to occur and the victims be compensated. It is therefore appropriate that an Act, which provides compensation to the victims of industrial accidents, should contain provisions dealing with prevention of such accidents".

The learned Commissioner, that is Mr. Justice Roach, went on to state, "In my respectful opinion the present provisions of the Act dealing with accident prevention are not adequate and need revision". He recommended measures: (a) to bring the subject of accident prevention in all the industries included in Schedule 1 (except mining) under the jurisdiction of the Board; (b) to give the Board power to investigate all places of employment to determine the adequacy of safety measures; (c) to make rules and regulations with respect to safety requirements and measures to prevent industrial diseases; (d) to carry on safety education and (e) to appoint advisory committees, representative of management and labour, to assist in establishing standards of safety and to recommend rules and regulations.

Not only have none of his recommendations been carried out, the Board now has, if anything, a weaker role and less jurisdiction in the matter of







1 accident prevention than it had at the time when he made  
2 his report.

3 On April 7, 1960, shortly after the  
4 tragic loss of several lives in a tunnelling accident at  
5 Hogg's Hollow, a Royal Commission on Industrial Safety  
6 was appointed under the chairmanship of His Honour  
7 Judge P. J. McAndrew. The Commission repeated the demand  
8 for more effective co-ordination of accident prevention  
9 work. Indeed the precise recommendation of Mr. Justice  
10 Roach for an amendment to The Workmen's Compensation Act  
11 (summarized above) was recommended again verbatim (pp.  
12 20-21) by the McAndrew Commission.

13 The McAndrew Commission criticized the  
14 functioning of the Accident Prevention Associations,  
15 established under the authority of s. 117 of the Act,  
16 because of their attitude, their limited authority and the  
17 lack of any provision for participation by labour in their  
18 work. The report stated, at p. 19: "The attitude of  
19 the associations is one of complacency with respect to  
20 their present functions, which are largely educational.  
21 Some of the associations employ inspectors or safety  
22 counsellors; but the inspectors, who are representatives  
23 of the employers, have no authority to enforce safety  
24 measures...few (rules) have been made, and none enforced,  
25 due no doubt to the ambiguity of the meaning of 'rules'...  
26 The complaint of labour is that the work of the accident  
27 prevention associations does not penetrate below the rank  
28 of foreman, and this is a valid complaint." The  
29 Commission then quoted with approval Mr. Justice Roach's  
30 statement that "My first criticism of the present system





1 is that it does not provide any means which will ensure  
2 the active participation of labour in the work of accident  
3 prevention. My second criticism is that the relationship  
4 between the Board and the associations is much too remote.

5 Again the McAndrew Commission repeated  
6 Mr. Justice Roach's recommendations for amendments to the  
7 Act which would strengthen the Associations, make them  
8 representative of labour as well as management and  
9 strengthen and co-ordinate their accident prevention  
10 efforts.

11 Instead of that being done, however,  
12 the Act has been amended to limit the function of these  
13 associations to "education in accident prevention" thus  
14 only weakening them still further.

15 THE COMMISSIONER: There was something  
16 else done, wasn't there? Wasn't the Board given some  
17 control over accident prevention?

18 MR. INGLE: I believe that in that  
19 section of the Act there was provision for additional  
20 control by the Board. It is in subsection (2), I think  
21 you are referring to.

22 "If the Board is of the  
23 opinion that an association so  
24 formed sufficiently represents  
25 the employers in the industries  
26 included in the class, the Board  
27 may approve such rules of opera-  
28 tion, and, when approved by the  
29 Board and by the Lieutenant  
30 Governor in Council, they are





1 binding on all the employers in  
2 industries included in the class."

3 Now, these can only be rules with respect to educational  
4 programs, because this is the area to which the  
5 associations' activity is limited.

6 THE COMMISSIONER: I think there has  
7 been some coordination of that branch, but, as you say,  
8 there is no means of putting teeth into their suggestions.

9 MR. INGLE: I think that is correct.

10 THE COMMISSIONER: I think there are two  
11 floors in a building over here on Yonge Street which  
12 are occupied by the Accident Prevention Association, but  
13 I understand that their work has been more or less  
14 coordinated and is under the direction now of the  
15 Director who operates under the instructions of the  
16 Board.

17 MR. INGLE: I believe that is so, sir.  
18 I am not criticizing the control which the Board  
19 exercises over the associations, but my criticism is of  
20 their limited function.

21 I want to interject, if I may, and  
22 endorse what was said in a brief which I understand was  
23 distributed but not actually presented to you, sir, by  
24 the Canadian Association of Professional Safety Men with  
25 respect to the misuse of the Board's funds amounting to  
26 some \$4 million a year and spent by these associations.  
27 That criticism is at pages 10 to 12, particularly page  
28 12, of that brief.

29 THE COMMISSIONER: He says that all that  
30 money which is expended doesn't achieve the result because







1 the workmen pay little or no attention to it. It isn't  
2 reaching the workmen; is that it?

3 MR. INGLE: That is correct, it is not  
4 reaching the worker.

5 THE COMMISSIONER: What is your sugges-  
6 tion on that?

7 MR. INGLE: There was criticism  
8 particularly of the Construction Association. In the  
9 Ottawa area a month or so ago, as everyone knows, there  
10 was a very serious accident involving the construction of  
11 a bridge, the Heron Road Bridge, and following that  
12 accident I am informed by people in Ottawa that the  
13 Construction Association continued to sponsor over Ottawa  
14 television stations an accident prevention message which  
15 was a film clip of a workman walking on a bridge and  
16 tripping. Now, it seems to me that that was a particularly  
17 insensitive thing to do. That is one of the criticisms,  
18 I understand, the safety men are making.

19 Now I go on to the next point, sir.

20 There has been a nod in the direction  
21 of labour participation through the establishment of the  
22 Labour Safety Council of Ontario under an amendment to  
23 the Department of Labour Act (Stat. of Ont. 1961-62, c.  
24 32). This, however, is a poor substitute for the active  
25 labour participation in accident prevention envisaged  
26 and recommended by both the Roach Commission and the  
27 McAndrew Commission through supervision of the work of  
28 strengthened and more authoritative accident prevention  
29 associations and the work of accident prevention  
30 committees at the plant level.





1                   Those are some of the things, sir, which  
2 we think should be done.

3                   I go on:

4                   Somework in the field of preventing  
5 industrial disease is now being done by the Environmental  
6 Health Branch (formerly the Industrial Hygiene Branch)  
7 of the Department of Public Health. It is our opinion  
8 that the industrial hygiene work of this branch is less  
9 adequate and less effective than it should be and we  
10 respectfully recommend that it be brought directly under  
11 the jurisdiction of the Workmen's Compensation Board.

12                  At present the work of the branch is  
13 on a consultative and service basis. An investigation  
14 of a particular health hazard is made by that branch  
15 only if it is specifically referred to them by an  
16 employer, employee, the Department of Labour, and so on.  
17 The technical experts of this branch go out with an  
18 inspector of the Department of Labour or Mines --- if a  
19 specific problem has been raised.

20                  The Branch undertakes no surveys on its  
21 own initiative and does no research work on the causes  
22 of industrial disease or on the effect of various work  
23 conditions on health of employees.

24                  I may say, sir, that I took the trouble  
25 to go directly to the branch and discuss the matter with  
26 the Director and some of his officers.

27                  The branch does not provide the  
28 Workmen's Compensation Board with copies of its report  
29 and recommendations after one of its investigations is  
30 completed. Neither is a copy provided to the union ---





1 even if an investigation has been undertaken as a result  
2 of a request or complaint by the union, though they are  
3 informed orally of the general results of the investiga-  
4 tion.

5 The branch employs only one engineer  
6 for the province to handle all investigations in all  
7 industries, into physical conditions, such as noise  
8 levels, vibrations, non-ionizing radiation, heat and so on,  
9 which may be hazardous to health. Obviously such a  
10 limited staff could not do an adequate job if the Branch  
11 took the initiative in making industrial health surveys  
12 or in doing research into industrial disease.

13 In contrast, in British Columbia,  
14 industrial hygiene is under the jurisdiction of the  
15 Workmen's Compensation Board and the B.C. Board undertakes  
16 a wide range of programs aimed at improving working  
17 conditions and at reducing the incidence of industrial  
18 disease. The following excerpts from the 1965 report of  
19 the B. C. Workmen's Compensation Board are quoted to  
20 show the scope of the B.C. programs in this field:

21 "A total of 225 inspections,  
22 surveys and investigations was  
23 made in industrial operations  
24 during 1965 to study the health  
25 aspects of the industrial environ-  
26 ments. Evaluation of the chemical  
27 and physical agents which cause  
28 industrial diseases and the  
29 development of controls to ensure  
30 compliance with the Workmen's







1 Compensation Board regulations come  
2 within the scope of the Industrial  
3 Hygiene Division.

4 "Detailed noise surveys were made  
5 in noisy industries to evaluate noise  
6 exposure and to develop suitable  
7 hearing-conservation programmes.  
8 Results of surveys demonstrate the  
9 need for noise reduction or ear  
10 protection in many operations.  
11 Industrial operations surveyed  
12 included sawmills, planer-mills,  
13 plywood manufacture, logging, shingle-  
14 mills, pulp-mills, paper-converting,  
15 printing, chemical manufacture,  
16 engine maintenance, rope manufacture,  
17 and gas transmission.

18 "A total of 520 body-fluid  
19 samples were analysed for lead to  
20 determine lead absorption by workmen  
21 in lead-battery plants and lead-  
22 reclamation plants. Atmospheric  
23 samples were also collected where  
24 lead absorption indicated a possible  
25 dust or fume problem, and  
26 corrective action was prescribed for  
27 control.

28 "The application of new types  
29 of protective coating to steel and  
30 wood surfaces was studied, and the





1 exposure to hazardous materials  
2 evaluated. Specification of protec-  
3 tive coatings containing injurious  
4 or highly flammable materials is  
5 creating special health problems  
6 that require controls. Application  
7 of protective coatings by airless  
8 spray equipment and electrostatic  
9 spraying also presents new problems  
10 in control.

11 Industrial contacts and exposures  
12 were also investigated in operations  
13 manufacturing: cement, plastics,  
14 acetylene, cable, wire cloth,  
15 chemicals, textiles, copper tubing,  
16 metal containers, ornamental ironwork,  
17 neon tubes, fertilizers, tires,  
18 coffee and tea, drill alloys, and  
19 in smelters, laundries, shipyards,  
20 furniture, protective coatings,  
21 bakeries, hospitals, engine main-  
22 tenance, fruit-packing, bridge steel,  
23 water and sewage treatment, and  
24 springs.

25 "Claims for dermatitis consti-  
26 tute the largest group of industrial  
27 diseases covered by the Schedule of  
28 Industrial Diseases."

29 I am informed that this is also the case in Ontario and,  
30 indeed, in every other jurisdiction.





1 "Inadequate protection for repeated  
2 contact with many industrial agents  
3 eventually results in a breakdown of  
4 the protective mechanism of the skin,  
5 and dermatitis results. Improvements  
6 in personal protection and improved  
7 methods of use of potential skin  
8 irritants is necessary.

9 "A total of 1,061 claims for  
10 industrial diseases was filed in  
11 1965.

12 "A total of 97 ventilation and  
13 dust surveys was made during 1965  
14 to evaluate exposures to pneumococonios-  
15 producing dusts and to determine  
16 the effectiveness of dust-control  
17 measures.

18 "Dust concentrations were deter-  
19 mined with a konimeter at underground  
20 construction projects, fertilizer  
21 plants, stone-cutting and dressing,  
22 asphalt-mixing plants, rock-crushing  
23 plants, and other industrial plants  
24 where there was an exposure to rock  
25 dust.

26 "The use of mechanical excavators  
27 in a sewer-tunnel project and a water-  
28 main project presented special dust  
29 and ventilation problems. The  
30 ventilation fans were operated on







1 exhaust duty from the face work area,  
2 and where feasible, water sprays were  
3 used as a dust-suppression measure  
4 on the excavator cutter-head. The  
5 results of dust surveys are being  
6 studied to determine the ventilation  
7 requirements and other measures  
8 necessary to provide more effective  
9 dust control to maintain a healthy  
10 environment.

11 "Requirements for control of  
12 dust at asphalt-mixing plants and  
13 at rock-crushing plants were issued  
14 October 1, 1964. Dust surveys in  
15 asphalt-mixing plants during 1965  
16 demonstrated that satisfactory  
17 dust control was achieved in several  
18 plants, but most of the plants  
19 require improvements in dust control.  
20 A few rock-crushing plants installed  
21 water sprays at the jaw and rolls  
22 crushers as a dust-suppression  
23 measure. The water sprays installed  
24 to date have not reduced the dust  
25 concentrations to a satisfactory  
26 level. Other means of dust control  
27 will be tested.

28 "Investigations continue regarding  
29 dust-control methods for drilling  
30 operations with air-leg and sinker





1 machines used during the construction  
2 of logging-roads. Satisfactory  
3 results on dust control are being  
4 obtained with the water-detergent  
5 method at the self-propelled rock-  
6 drill units used on road construction.

7 "Tests were made for noxious  
8 gases and combustible gases at  
9 tunnelling operations for road  
10 construction, water mains, sewer  
11 tunnels, dam construction, and hydr-  
12 development projects."

13 It is respectfully submitted that work  
14 of the kind indicated in this report will ultimately  
15 more than pay for itself, not only in terms of reduced  
16 compensation costs, but far more important, in terms  
17 of healthier happier people. So far as is known, little  
18 or none of such work is going forward in Ontario.

19 THE COMMISSIONER: Of course, in the  
20 Province of Manitoba none of it comes under the  
21 Compensation Board. It is all under one government  
22 department or government supervision in all those areas.

23 MR. INGLE: I believe that is correct, sir.

24 THE COMMISSIONER: Can you tell me in  
25 British Columbia whether there is any contribution,  
26 financial contribution by the province to the Board to  
27 take care of this work?

28 MR. INGLE: I have looked through the  
29 reports of the legislation and also Mr. Justice Tysoe's  
30 report, and I find no reference to any such contributions.





1 There is provision in the Act for contributions, as there  
2 is, indeed, in our Act, but I don't know whether, in fact,  
3 it is existing in fact. From the brief look I had at the  
4 financial statements of the B. C. Board I see no reference  
5 there to any contribution by the government to any aspect  
6 of the Board's work. I can undertake to find that out,  
7 sir.

8 THE COMMISSIONER: I believe we are  
9 going to get this in more detail next week.

10 MR. INGLE: I will find out about that  
11 and inform you.

12 THE COMMISSIONER: Some of this work,  
13 you say, has been carried out very inadequately at the  
14 moment by certain provincial government departments, and,  
15 based on what you indicate has been done in British  
16 Columbia, a great deal more can be done. If we cut down  
17 on the incidence of injury and disease, the compensation  
18 fund would benefit, but at first sight it would look as  
19 if it would involve the Board spreading out a good deal.  
20 If they have two floors over there now, it looks as  
21 though they would need a great deal more. It is a  
22 question of where this control should be.

23 MR. INGLE: I think it is partly that  
24 and also the jurisdiction of this industrial hygiene  
25 branch, wherever it may be.

26 THE COMMISSIONER: They don't want  
27 overlapping either.

28 MR. INGLE: That is right. I want it  
29 made clear, if I haven't done so, that I imply no  
30 criticism of Dr. Robertson and his staff. It is just







1 that, I suggest, it is too limited.

2 THE COMMISSIONER: You are talking about  
3 the health branch?

4 MR. INGLE: I think it is now called  
5 the Environmental Health Branch of the Department of  
6 Public Health.

7 I remember when the Tysoe Committee was  
8 set up the suggestion was made that the Industrial Hygiene  
9 Department of the Workmen's Compensation Board may be  
10 separated from the Board, as ours is now, and Mr. Arthur  
11 Francis, the Director of Accident Prevention in British  
12 Columbia --- this is found at page 133 of the Tysoe  
13 Report --- when that suggestion was made to him, said:

14 "Well, first of all, I don't  
15 think that the Board or the Claims  
16 Department could properly adjudi-  
17 cate claims for industrial diseases  
18 without the information they are  
19 now getting from the Industrial  
20 Hygiene Department. To wait for  
21 an outside agency to supply them  
22 with this information would hold up  
23 the adjudication of claims.

24 "Also, there is a tendency  
25 to think of industrial hygiene  
26 problems as something entirely  
27 separate from the usual procedures  
28 in an industrial operation. Actually,  
29 they are part and parcel of the  
30 accident-prevention inspector's





1 work up to a point where it becomes  
2 too technical for him to handle.

3 "The main responsibilities of  
4 the Industrial Hygiene Department  
5 are not merely the coding of claims  
6 or assisting in their adjudication,  
7 but it is to institute preventative  
8 measures, and the safety inspectors  
9 in their daily rounds come across  
10 many items with which they are  
11 capable of dealing, and if they  
12 are not they can consult with the  
13 Industrial Hygiene Department and  
14 either get advice to take certain  
15 actions or the Industrial Hygiene  
16 Department would go in if it was  
17 a matter of taking samples and  
18 analyzing certain things."

19 You will note that Mr. Francis did not say that the  
20 inspectors would be in a position to say, "Well, this is  
21 not my responsibility, this is not my jurisdiction. This  
22 is the responsibility of the Department of Public Health."

23 "...the functions", he goes on to say,  
24 "of the Industrial Hygiene  
25 Department to be carried out  
26 whether or not it is a separate  
27 section of the Board, but it  
28 is certainly an inseparable"

29 I underline that ----

30 "part of the duties of the Board."





1 Mr. Justice Tysoe, on the same page,  
2 underlined that. He said on the same page (p. 123):

3 "The evidence is overwhelmingly  
4 in favour of continuance of the  
5 Industrial Hygiene Division of  
6 the Board as part of the Board  
7 administration and enlargement  
8 and expansion of its services, and  
9 I agree with this evidence."

10 ~~He~~ gave the matter very serious consideration.

11 THE COMMISSIONER: To go back to the  
12 situation here, the Environmental Health Branch of the  
13 Department of Public Health has these inspection  
14 responsibilities. Is there a branch under The Mining Act?

15 MR. INGLE: Not as far as I know. I am  
16 informed that there is not. Mr. Storey will answer that.

17 MR. STOREY: For example, if there was  
18 a dust condition in a mine an employee or the union may  
19 ask for a test to determine the situation and the  
20 Department of Public Health goes in.

21 THE COMMISSIONER: That is the  
22 Department of Public Health. There is nothing under The  
23 Mining Act?

24 MR. STOREY: That is right.

25 THE COMMISSIONER: There is examination  
26 for a periodical examination, yearly examination?

27 MR. STOREY: Yes.

28 THE COMMISSIONER: That comes under  
29 The Mining Act?

30 MR. STOREY: Yes.







1 THE COMMISSIONER: That in turn is  
2 adopted by the Workmen's Compensation Board?

3 MR. INGLE: I am coming to this particular  
4 point in a moment. It is Section 167 of The Mining Act.

5 THE COMMISSIONER: I am just trying to  
6 cover this point here at the moment. All other  
7 situations that you mention you believe come under the  
8 Department of Health.

9 MR. INGLE: The Department of Public  
10 Health, yes. I am informed by that branch and the  
11 Workmen's Compensation Board that they have a very close  
12 liaison now, but it is our submission that they should  
13 be under the jurisdiction of the Board.

14 THE COMMISSIONER: Even if they are under  
15 the jurisdiction of the Board the Board still would not  
16 have any power to put into effect any of these  
17 recommendations, would they?

18 MR. INGLE: I submit that they should  
19 have that power, that they are transferred to the Board,  
20 to initiate surveys, the same as in British Columbia.

21 THE COMMISSIONER: That is with regard  
22 to surveys. Suppose they come in and find a situation  
23 they don't approve of, what happens?

24 MR. INGLE: The Board, it seems to me,  
25 should have authority to correct that situation. Mr.  
26 Storey reminds me now that under The Industrial Safety  
27 Act the inspector has that authority now.

28 THE COMMISSIONER: Which inspector?

29 MR. INGLE: The inspectors under The  
30 Industrial Safety Act have this kind of power now.





1 THE COMMISSIONER: Who appoints the  
2 industrial inspectors?

3 MR. STOREY: The Department of Labour,  
4 sir.

5 THE COMMISSIONER: Then you have the  
6 Environmental Health Branch making inquiries; in some  
7 cases you have the examinations done by the Workmen's  
8 Compensation Board, and then you have the Department of  
9 Health.

10 MR. STOREY: Industrial Safety Branch of  
11 the Department of Labour. Page 32, the next part of our  
12 brief, sets out the various Acts involved.

13 MR. INGLE: Yes, sir, I was just going to  
14 answer that.

15 Accident prevention in industry is now  
16 divided among several bodies under various acts, including  
17 The Industrial Safety Act, 1964 (Stat. of Ont. 1964, c.  
18 45), The Construction Safety Act, 1961-62 (Stat. of Ont.  
19 1961-62, c. 18), The Elevators and Lifts Act, (R.S.O. 1960  
20 c. 119), The Trench Excavators' Protection Act, (R.S.O.  
21 c. 407), The Construction Hoists Act, 1960-61 (Stat. of  
22 Ont. 1960-61 c. 11), The Loggers' Safety Act, (Stat. of  
23 Ont. 1962-63, c. 76), The Department of Labour Act, (R.S.O.  
24 1960, c. 97), et cetera.

25 Co-ordination is very limited and  
26 inadequate.

27 This point was touched on in the brief  
28 of the Labourers' Local 183 of the Labourers' International  
29 Union, and we would like wholeheartedly to endorse and  
30 reiterate what they said at pages 21 and 22 of their brief.





1 "In some areas there has been  
2 a wasteful duplication of inspection  
3 while in others, there has been a  
4 shocking absence of inspection or  
5 regulation of any sort."

6 Then again at page 24 they state:

7 "What is needed to remedy  
8 these various problems is a single,  
9 centralized, co-ordinating agency  
10 to marshall the concerted efforts  
11 and resources of employers, work=  
12 men and government towards an all=  
13 encompassing safety inspection  
14 and regulation program."

15 We suggest that that body should be the Workmen's Compens=  
16 sation Board.

17 THE COMMISSIONER: It is getting more  
18 complicated than ever if we get into all those.

19 MR. INGLE: I think somebody has got to  
20 take a look at this.

21 THE COMMISSIONER: Maybe the answer  
22 would be that it is taken away from the Board and placed  
23 under some provincial authority.

24 MR. INGLE: I believe that would not  
25 be the answer, sir, if I may say so, with respect. I  
26 think the importance of tying accident prevention in with  
27 compensation is that it warrants one authority of that  
28 jurisdiction in this field.







FN/SS 1

2 The Labour Safety Council of Ontario  
3 has been established under an amendment to the Department  
4 of Labour Act and is comprised of the Presidents of the  
5 seven accident prevention associations together with seven  
6 labour representatives. This body, which for the first  
7 time gives labour some voice in safety matters at a high  
8 level, is undertaking some useful work in initiating the  
9 development of a safety code and some research on causes  
10 of accidents.

11 But the functions of the Council are  
12 advisory only and it cannot undertake the co-ordination  
13 and over-all supervision of safety measures which is  
14 required. And now we refer, sir, to the point you just  
15 mentioned a moment ago, about the Mining Act.

16 One of the anomalies of the present  
17 decentralized jurisdiction over and lack of co-ordination  
18 of accident prevention is that by section 167 of the  
19 Mining Act (R. S. O. 1960, c. 241) certain medical  
20 examinations are required of persons employed in dust  
21 exposure occupations. But these examinations may only be  
22 made by medical officers appointed for that purpose under  
23 The Workmen's Compensation Act. It is respectfully  
24 submitted that the provisions of Section 167 of The Mining  
25 Act should be transferred to The Workmen's Compensation  
26 Act.

27 THE COMMISSIONER: Surely that is not very  
28 important, is it? I mean to say, Section 167 of The  
29 Mining Act requires certain medical examinations, but  
30 actually the work that is required to be done by medical  
officers employed by the Workmen's Compensation Board, we





1 were told that the explanation of this anomaly is that  
2 in this particular industry where it was felt that these  
3 preliminary examinations were necessary or yearly examina-  
4 tions that this was a means of assessing the cost of it  
5 to a particular industry ---- it was assessing the cost  
6 most easily by this method.

7 MR. INGLE: I have not heard this  
8 explanation for this division. It seems to me, though,  
9 if that is the sole purpose of having this provision in  
10 another Act it could be achieved without going through all  
11 this business of having two separate Acts dealing with the  
12 same problem and the requirements for inspection in one  
13 Act under one jurisdiction be made by people appointed  
14 under another Act, and another board.

15 Mr. Dowling reminds me that the  
16 Workmen's Compensation Board have jurisdiction over the  
17 assessments but they do not have jurisdiction over the  
18 situation, at least they don't have control over the  
19 situation.

20 THE COMMISSIONER: Well, do they appoint  
21 these men? Do these appoint these doctors?

22 MR. INGLE: The Workmen's Compensation  
23 Board appoints the doctors.

24 THE COMMISSIONER: And pays them but has  
25 no jurisdiction over them other than that?

26 MR. INGLE: Precisely.

27 Similarly, there is another anomaly in  
28 Section 198 of the Mining Act, this is another subject,  
29 which provides that first aid supplies shall be maintained  
30 at every mine as "required by the regulations under The





1 Workmen's Compensation Act". There is, however, no  
2 special provision in the regulations for first aid  
3 requirements for miners, as there is in Section 19 of  
4 the regulations for bush workers, despite the need for  
5 special first aid equipment in the case of mining  
6 accidents.

7 THE COMMISSIONER: There are no  
8 regulations, is that what you say?

9 MR. INGLE: They are general  
10 regulations in respect of first aid, but no specific  
11 regulations as to first aid at mines. There are regulations  
12 in respect of bushworkers and other industries. We have  
13 made a specific recommendation with respect to this  
14 matter at the top of page 33.

15 It is therefore recommended that  
16 the provisions of Section 198 of  
17 The Mining Act be transferred to  
18 The Workmen's Compensation Act  
19 and that provision be made in  
20 the regulations for the same first  
21 aid requirements as are contained  
22 in Section 19 of the regulations  
23 for employers of bush workers  
24 with the following additions:

25 "f) a metal mesh basket and one  
26 hemp rope and one marlin rope;

27 "g) a low-built white truck on  
28 rails which can be pushed to  
29 the shaft for the transporta-  
30 tion of injured workers".







1 Now, with that kind of addition to the Act we feel that  
2 the first aid requirements for bushworkers could also be  
3 applicable to miners.

4 THE COMMISSIONER: I don't know anything  
5 about mining. I suppose these requirements are not very  
6 onerious.

7 MR. INGLE: I would not think so, sir.

8 THE COMMISSIONER: I was just thinking  
9 of a small operation where there are not many people  
10 involved.

11 MR. INGLE: It would not be very costly  
12 and if you look, sir, at the other requirements of  
13 Section 19 none of them are very costly; they are what  
14 we suggest are minimal requirements that any mine should  
15 have.

16 One or two of the safety acts mentioned  
17 previously, provide for some co-ordination with the  
18 Workmen's Compensation Board but these provisions are  
19 minimal and inadequate. For example, Section 48 of  
20 Ontario Regulation 196/64 made under The Industrial  
21 Safety Act (Stat. of Ont. 1964, c. 45) provides that a  
22 copy of the accident report required under Section 115  
23 of The Workmen's Compensation Act may be accepted for  
24 purposes of The Industrial Safety Act. A similar provision  
25 has been made in Sec. 9 (3) of The Loggers' Safety Act  
26 (Stat. of Ont. 1962-63, c. 76). It is our contention  
27 that all industrial accidents should be reported to the  
28 Workmen's Compensation Board and that copies of such  
29 reports be made available to employees and to any  
30 organization of employees requesting them.





1 We have noted that in the brief of the  
2 Canadian Association of Professional Safety Men they also  
3 have called for better and more comprehensive reporting  
4 of accidents and unsafe working conditions to the  
5 Workmen's Compensation Board by the various safety  
6 branches of the Department of Labour and the municipalities.  
7 This is contained in pages 8 and 9 of their brief. I  
8 don't know if this brief is now available to this  
9 Commission or not, but I hope it is.

10 THE COMMISSIONER: Well, I still have  
11 my copy.

12 MR. INGLE: It is respectfully  
13 submitted that the proper body to undertake overall co-  
14 ordination and supervision of industrial safety and  
15 industrial hygiene in Ontario is the Workmen's Compensa-  
16 tion Board.

17 The Commission's attention is drawn to  
18 the fact that in Alberta, British Columbia, Newfoundland  
19 and Saskatchewan, accident prevention comes under the  
20 jurisdiction of the Workmen's Compensation Boards of  
21 those provinces.

22 THE COMMISSIONER: When you say accident  
23 prevention it comes under the jurisdiction here too, but  
24 you are referring to the sort of thing that is happening  
25 in British Columbia, I suppose.

26 MR. INGLE: Yes, sir, with respect, sir,  
27 I believe it does not come under the jurisdiction of the  
28 Board here, except in respect of the educational work  
29 undertaken by the associations and with that exception  
30





1 there is no jurisdiction of the Board here over accident  
2 prevention.

3 I would just add one thing and then I am  
4 through with this part of my submission, sir. I would  
5 like to quote in this connection, that is with respect to  
6 accident prevention, from Mr. Justice Tysoe's report at  
7 page 95 where he says this:

8 "I conclude this part of my  
9 Report" ---

10 he was dealing there with Board administration.

11 "...by urging the Board not to measure  
12 the success of its administration by  
13 the balance-sheet and  
14 particularly not by the amount of  
15 the administrative expenses.  
16 Money well spent on such matters  
17 as accident prevention and  
18 rehabilitation services may result  
19 in a much greater saving-in dollars - in  
20 the amounts that have to be dispersed  
21 for medical aid, time loss and  
22 pensions."

23 I note, sir, that it is almost one o'clock and I under-  
24 stand you usually rise at one o'clock. I have some  
25 additional brief submissions I would like to make,  
26 particularly in respect of the submissions made by the  
27 International Nickel Company and I would appreciate an  
28 opportunity of continuing our presentation for a brief  
29 time after the recess.

30 THE COMMISSIONER: We will adjourn until  
two o'clock. Luncheon Adjournment ---







1 ---On resuming at two o'clock p.m.

2  
3 MR. INGLE: I should like to, before I  
4 deal with the brief of the International Nickel Company  
5 in two or three of its aspects, say that I understand that  
6 the International Nickel Company and one or two other  
7 employers have referred to the Commission a total of  
8 some 22 individual cases in which compensation was  
9 awarded and they allegedly have no merit. These are now  
10 under investigation.

11 I may say that our union has not  
12 brought any individual cases forward for examination  
13 because we understood that the jurisdiction of your  
14 Commission, sir, specifically excluded the consideration  
15 of the detailed administration of the Board. But I want  
16 to say here the fact that we are not bringing such cases  
17 forward does not mean that there are not cases, a good  
18 many of them, that we could bring forward where we feel  
19 that the man has been denied compensation that should  
20 have been awarded.

21 THE COMMISSIONER: I have had numerous  
22 letters in which people have sought to have me interfere  
23 in connection with individual cases and you are quite  
24 right, I have no jurisdiction to sit on appeal from this  
25 Board as far as individual cases are concerned.

26 The Labourers' International Union  
27 brought in certain cases, but I understood them to be  
28 as examples of the point which they were trying to make.  
29 I don't remember that there were 22, I think one or two  
30 were mentioned. Maybe they undertook to produce some more.





1 International Nickel brought some in for the same purpose.  
2 In no case have I been asked to deal with the merits of  
3 any individual case.

4 MR. INGLE: I appreciate that  
5 clarification. The only reason I mention it now was that  
6 our failure to bring forward any such cases does not  
7 mean that we have been totally satisfied from our point of  
8 view with the dealing with individual cases. We feel  
9 this is not the proper place for dealing with such  
10 matters.

11 I indicated when I was dealing with  
12 Section 41 of the Act that I would have something later  
13 to say about that. I would now like to do that with  
14 respect to the brief that has been submitted to you by  
15 the International Nickel Company. I am concerned at this  
16 point with the section of that company's brief commencing  
17 at page 20 in their section headed "Rehabilitation of  
18 Injured Employees", Sections 20 to 22, and on page 21 of  
19 their brief the company suggests that compensation for  
20 temporary total or temporary partial disability should  
21 be reduced or terminated in certain cases as a means of  
22 coercing an injured employee back to his normal work  
23 saying in effect to him, "You had better into line or  
24 else!".

25 Now, the brief stresses, that is the  
26 International Nickel Company brief stresses the  
27 importance in this section of the injured man's  
28 cooperation in a successful rehabilitation program. I  
29 am not taking anything away from that, but the point I  
30 want to make is that the employer's cooperation is also





1 important. In some of the practices of some employers  
2 including the International Nickel Company, in our opinion,  
3 things militate against a proper rehabilitation program.  
4 I am going to cite two examples that illustrate my point.  
5 One is the kind of cooperation that an employer can give  
6 which assists in the successful rehabilitation of an  
7 injured employee and another one which is just the  
8 opposite.

9           Using these examples I will use for  
10 the benefit of the Board or anyone else who wants to  
11 look into them the numbers of the cases only and not the  
12 men's names. The first one, a good example is Board  
13 Case No. 6290571. This man was injured in December,  
14 1964 at the 1500-foot level --- an injury of a kind that  
15 resulted in damage to his head and his neck, so that he  
16 could not wear his hard hat and the company put him on  
17 light duty on the surface. In December of 1964 he was  
18 returned underground. On the 11th of February, 1965 he  
19 had a recurrence of the injury and the company arranged  
20 for him to have six months of work around the personnel  
21 office and later some four months' work in the warehouse  
22 doing sweeping and this kind of thing before returning  
23 to the mine. The man was successfully rehabilitated.  
24 This I cite as an example of the kind of thing that  
25 exists in successful rehabilitation. The other one is  
26 C-6805245, the case where a man was injured on May the  
27 25th of this year. He was working in a slusher trench  
28 at the 1,000-foot level when a box-hold let go and his  
29 foot and leg were crushed by some chunks of material.

30           He was taken to the surface in a







1 basket and to the hospital where his leg and his foot were  
2 placed in a cast to the knee. This man lost two days'  
3 work and then he was pressed by his supervisors to go  
4 back to work so as to avoid having the company charged  
5 with a lost time accident and he went back into the  
6 plant on crutches, he punched the clock and sat in the  
7 dry and did and does nothing. His pre-accident rate was  
8 \$104.00 per week, his reduced pay as a partially  
9 disabled man is \$86.90 and the Workmen's Compensation  
10 Board now makes up some of the balance. The only reason  
11 for this action, it is quite apparent, was so that the  
12 company could have a lower assessment.

13 The man in his report says this:

14 "I am physically present at the  
15 the plant, I am not required or  
16 able to do any work".

17 Now, I suggest that when the company talks about the  
18 cooperation of individual employees in rehabilitation the  
19 cooperation of the employer is equally necessary and the  
20 kind of case which I have just cited and which is not, by  
21 the way, isolated, is the sort of thing that wrecks any  
22 successful rehabilitation program.

23 THE COMMISSIONER: Isn't he better off  
24 back at work with the company than on compensation?

25 MR. INGLE: Well, in this case if the  
26 man is totally disabled as he well may be he shouldn't  
27 be back in the plant at all, and that accident should be  
28 reported to and treated by the Board as a lost time  
29 accident. The only reason for treating him in this way  
30 is so that the company can lower its rate of lost time





1 accidents.

2 THE COMMISSIONER: They may be up some  
3 place where it is going to make a difference, but so far  
4 as the man is concerned in the case you are talking about,  
5 isn't he better off financially under the circumstances  
6 than if he went on compensation?

7 MR. INGLE: He is as well off and perhaps  
8 better off, but I am suggesting that aside from the  
9 individual advantage to the employee in monetary terms  
10 there is nothing being done so far as rehabilitation is  
11 concerned by the way in which he is being treated.

12 THE COMMISSIONER: Well, it is not  
13 intended that he be there forever. I don't imagine they  
14 would want him there forever doing nothing.

15 MR. INGLE: Well, he is there and he is  
16 doing nothing and being paid for doing nothing.

17 MR. ESTEY: How much is he getting paid,  
18 did you say \$86.00?

19 MR. INGLE: My information is \$86.90 by  
20 the company.

21 MR. ESTEY: And part of the difference  
22 is made up by the Board?

23 MR. INGLE: That is right.

24 MR. ESTEY: You don't know how much?

25 MR. DOWLING: 75 percent.

26 MR. HICKEY: I don't know exactly, but  
27 it should be 75 percent.

28 THE COMMISSIONER: This is a case where  
29 it is with the cooperation of the Board that he is back  
30 in there. This is probably to give the man something to





1 do and give him some personal advantage. That is why they  
2 are paying part of the cost.

3 MR. INGLE: If he were given something to  
4 do I would have no complaint. He is not given anything.  
5 I may say that this case has been fully reported to the  
6 Board.

7 THE COMMISSIONER: It would have to be if  
8 the Board was paying a portion of it, but in that event  
9 I don't know how it could be argued that it would lower  
10 the company's assessment in that area because they would  
11 obviously have to notify the Board.

12 MR. INGLE: It is only that if he is  
13 not off two days they don't have a lost time accident.

14 MR. ESTEY: It would only be three-quarters  
15 of \$18.00 they would be charged with.

16 MR. INGLE: That is correct, Mr. Estey.

17 When an injury first occurs it is our  
18 experience that company officials are immediately  
19 concerned with the factor: Is this going to be a lost  
20 time accident? And men are solicited to return to work  
21 almost immediately.

22 MR. ESTEY: Could I interrupt just before  
23 you leave that number which I get as 6805245.

24 MR. INGLE: Excuse me, Mr. Estey, there  
25 is a "C" preceding that --- C-6805245.

26 MR. ESTEY: I take it the man is  
27 receiving a disability payment.

28 MR. INGLE: So I understand.

29 MR. ESTEY: Therefore the three-day period  
30 must have been complied with somehow to qualify.







1 MR. INGLE: Well, he lost two days.

2 MR. ESTEY: Two days plus the day he is  
3 hurt, and that would qualify him. That would explain it  
4 and then your real point is that the company is saved  
5 three-quarters of \$104.00 as against three-quarters of  
6 \$18.00, that is the issue?

7 MR. INGLE: That is right.

8 When a man has been injured, when he  
9 fails to show up for work telephone calls are made to him  
10 and to his doctor regarding his condition. "Can't he  
11 come back to work?" This harrassment, as I call it, this  
12 is harrassment and many calls are made not only to the  
13 individual man and to the doctor, but the man in turn  
14 calls the union regarding the problem. "Do I have to go  
15 back to work?" "What will happen if I do go back?"  
16 "What will happen if I don't". It is quite evident from  
17 the type of inquiry that our union receives that this  
18 sort of pressure from the company, repeated calls and  
19 what-not, is extremely disturbing to the injured man.  
20 These are injuries such as broken legs, ankles, arms,  
21 wrists, and so on. This kind of pressure is evidently  
22 what the company means when it talks about rehabilitation  
23 in the brief, and now they want to add, as they say on  
24 page 21 of their brief, to this stricture that if a man  
25 refuses to cooperate in such rehabilitation procedures,  
26 if you could call them that, he should endure termination  
27 or reduction of temporary total or temporary partial  
28 disability and the denial of the right of permanent  
29 partial disability. I suggest that this is, if I may  
30 understate it, a rather harsh and unworthy proposition.





1 One can imagine what the company, based on its past  
2 practice would do, if such a weapon were placed in its  
3 hands.

4 THE COMMISSIONER: I understand what you  
5 say and what you say is --- I also know, though, from a  
6 medical standpoint in many cases it is desirable for the  
7 man to get back to work rather than to be laying off work  
8 for his own physical welfare. Both cases are always  
9 difficult, no doubt. One doctor will say, "Go to bed for  
10 two weeks" and another doctor will say, "You had better  
11 get back on the job", and they are doing it on the basis  
12 that that is the best thing that can happen <sup>to a</sup> man if he  
13 is particularly ~~neurasthenic~~ or something like that.

14 MR. INGLE: This is precisely why I  
15 mentioned the first case. This man was partially disabled  
16 and the company there cooperated in rehabilitating him to  
17 the extent of seeing that he got light work over an  
18 extended period, It assisted the man, it is quite correct.  
19 It was a therapeutic process from the medical point of  
20 view, I recognize that. This is exactly the point I am  
21 making with respect to the second case.

22 I turn now to an extensive part of the  
23 brief of the International Nickel Company concerning back  
24 injuries. There is a statement made on page 22 of their  
25 brief:

26 "During the period between 1951  
27 and 1965 the physical effort  
28 required on a large proportion  
29 of the jobs has substantially  
30 lessened due to technological





improvements."

This is not necessarily the case. I would like to take one particular and important illustration of the point I want to make here. Prior to the year 1953 a machine was used by this company called the ~~leyner~~ machine, used to drill blast holes in drifts and stopes. It consisted of a vertical bar fixed to the floor and the roof and a horizontal bar which moved up and down that vertical shaft and carried the weight of the drill. The drill itself was a heavy machine weighing some 200 pounds, but once it was on that bar it took a fair amount of effort, it is true, to get the drill onto the bar, but once it was on the bar it could be moved up and down fairly readily for drilling purposes, and I understand that from the one position in which that equipment could be fixed some 27 holes which are usually required to be drilled for blasting on the face of the drift could be drilled before the machine had to be moved to another position.

Now, about 1953 a new machine, a so-called jack-leg machine was introduced which consisted of a leg fixed at an angle in the floor and the drill supported at the top end of that leg. This drill only weighed about 70 pounds and its big advantage from the point of view of the company is its mobility. I am informed that some 50 minutes of time can be saved in moving the new machine as compared with the old liner machine, but at the beginning of each hole to be drilled, at the start of the drilling of each hole, this new drill must be cradled in the left arm and the right arm operates the controls while the hole is what is called







1 collared, that is, while it is properly located and  
2 properly started. This must be done by hand, the  
3 cradling of the machine is taken by the crook of the  
4 left arm. This process of collaring the hole takes any-  
5 where from half a minute to two minutes of time per hole  
6 depending on the experience of the operator and the  
7 location of the hole and so on, and this must be done  
8 some 27 or 30 times per rock face.

9           After the hole is collared the machine  
10 must then be held for the first four feet or so in order  
11 that the machine is not forced up by the pressure from  
12 the leg and the hole thrown out of line. Now, this  
13 machine has resulted not only in more back injuries, but  
14 in more serious back injuries and we have all kinds of  
15 cases that will illustrate this point. This is an  
16 instance where a new and improved machine has done the  
17 very opposite of what the International Nickel Company  
18 states is done in their brief with the new technological  
19 improvements and I am informed that now a newer and even  
20 heavier jack-leg machine is being introduced weighing  
21 some 120 pounds and there will undoubtedly be more back  
22 injuries and more serious back injuries as a result of  
23 the introduction of the new and heavier machine.

24           This is not something that affects just  
25 a few of the employees of the International Nickel  
26 Company. I am informed that there are some 2,000 men  
27 in the employment of this one company who are required  
28 to use this particular machine. So that I suggest, first  
29 of all, when International Nickel are concerned about the  
30 number of back injury claims that the introduction of new





1 machinery --- and this is an illustration of it --- in  
2 many cases actually results in increases in the number of  
3 back injuries. But there are other factors, there are  
4 three or four of them that I should like to mention with  
5 respect to the increase in the number of back cases.

6 The first is that the introduction of  
7 new and unfamiliar machinery will in itself tend to  
8 result in more accidents until the working force becomes  
9 familiar with that new equipment and new machine.

10 The second additional point that I  
11 would like to make is that a contributing factor to  
12 increase in number of injuries is the turnover in men and  
13 if one looks at one of the tables that was submitted by  
14 the Workmen's Compensation Board to your Commission the  
15 other day, Table No. 3, the Rate No. 076, I think,  
16 if I am not mistaken, covers the International Nickel  
17 Company and the figures on the total amount of compensa-  
18 tion are shown there for the years 1960 to 1965  
19 inclusive. If you look at the change between 1960 and  
20 1961 you will see that total compensation claims between  
21 those two years went up some \$25,000, \$26,000. One must  
22 also be aware, though, that between those two years the  
23 company took on a large number of green employees.  
24 Between the years 1962 and 1963, to take another  
25 instance, the total amount of compensation payable for  
26 this group was some \$5,000 less, a decrease, and this  
27 is a reflection of the fact that some 850 men were laid  
28 off by the International Nickel Company in 1962.

29 If we look at the figures 1964 to 1965,  
30 there is a very substantial increase in compensation





1 claims paid. From 1964 the company began taking on men  
2 again. Only some 700 former employees were re-hired, at  
3 least they accepted employment, and the balance of the  
4 additions to the work force were new men.

5 In the year 1965 between January and  
6 December there were 3,355 Inco employees who left the  
7 employment of the company, but in the same period the  
8 total work force of that company is up by some 1,057  
9 employees, and many of them recruited from different  
10 parts of Canada, large numbers were brought in from,  
11 for example, Newfoundland who had had no experience  
12 previously in mining at all.

13 I suggest that this is an important  
14 factor to be taken into account in looking at the increase  
15 in the number of compensable claims that have been  
16 allowed with respect to this particular company.

17 Another factor is, and the Board and at  
18 least the Commission should be aware of this, considering  
19 the statements made by the International Nickel Company,  
20 that prior to November, 1963 this company operated its  
21 own medical plan using company-employed doctors. Men  
22 made a contribution of \$1.00 a month or something like  
23 that and they were treated by, as I say, the company=  
24 employed doctors, and the tendency was --- those doctors  
25 I suppose were only human, to be more sympathetic to the  
26 company's position in respect of compensation claims.  
27 Since November, 1963 these men have been free to go to  
28 doctors of their own choice and that, I think, is another  
29 factor in the increased number of compensation claims.

30 Finally, and I think this is perhaps the







1 most significant of any of the factors, both the  
2 predecessor union to our own and the Steelworkers have  
3 carried on a very intensive campaign in recent years  
4 among employees of the International Nickel Company to  
5 report every accident and injury and to the extent that  
6 that campaign to report injuries has been successful this  
7 is reflected in part in the substantially increased  
8 number of compensation cases.

9 All of these things that I have  
10 mentioned have been factors.

11 The final point I want to make in  
12 respect of the brief of the International Nickel Company  
13 is that concerning back injuries. On page 25 of their  
14 brief they make this statement:

15 "This company accordingly  
16 submits most forcibly that  
17 provision should be made in  
18 the Act to show clearly that  
19 in order to receive an award  
20 for back disability suffered  
21 by a workman, there must be  
22 a direct causal relationship  
23 to an event occurring at work  
24 of a sufficient degree of  
25 severity that there can be no  
26 doubt that the disablement  
27 resulted from it."

28 I would like to draw to the Commission's attention and  
29 also to International Nickel Company's attention -- I am  
30 sure I don't need to do this as far as Mr. Osler is





1 concerned, he is already familiar with it, perhaps the  
2 most famous Workmen's Compensation back injury case in  
3 Canadian history. This is The Workmen's Compensation  
4 Board versus Theed. I don't know whether it has been  
5 referred to before the Commission or not, the citation is  
6 1940 S.C.R. at 543. This is a decision of our highest  
7 court, the Supreme Court of Canada, with respect to the  
8 problem of back injuries.

9 In this case a stenographer was required  
10 to operate a machine that was too heavy for her and over  
11 a period of a number of days of operating this machine  
12 she sustained a back injury and the Workmen's Compensation  
13 Board of, I believe it was, New Brunswick said when her  
14 claim came in "This is not the result of a particular  
15 traumatic event. There was no accident as such", and  
16 they denied her claim.

17 The case was taken ultimately to the  
18 Supreme Court of Canada and I would like to read a couple  
19 of excerpts from the decisions of members of that Court  
20 in respect of this problem.

21 THE COMMISSIONER: What do you say the  
22 name of that case was?

23 MR. INGLE: The Workmen's Compensation  
24 versus Theed. Mr. Justice Crockett at page 561 of the  
25 Supreme Court Reports said this:

26 "The learned counsel for the  
27 Board in his argument before us  
28 suggested that the decision, (that  
29 is the decision on the claim for  
30 compensation) . . .





1 "proceeded on the ground that the  
2 injury was one which gradually  
3 developed during the period in  
4 which she was required to operate  
5 the machine and was for that reason  
6 not the result of any one  
7 particular strain or any strain  
8 which it was possible to identify  
9 as having occurred on an particular  
10 day."

11 This is precisely the point made in the Inco brief:

12 "If this were the basis of  
13 the Board's decision that the  
14 injury was not caused by an  
15 accident, then I think with all  
16 respect for the reasons I have  
17 already indicated the Board  
18 misdirected itself as to the  
19 law."

20 "As to the extract from the  
21 speech of Lord Atkin which is  
22 not relevant to this)---

23 "it should be observed that  
24 he is careful to point out that  
25 while the distinction between  
26 accident and injury must be  
27 observed, it is hardly possible  
28 to distinguish in time between  
29 the two where a man suffered from  
30 a rupture, an aneurism burst, the







1 muscular action of the heart fails  
2 while the man is doing his ordinary  
3 work, turning a wheel or a screw or  
4 lifting his hand. In fact, as  
5 Lord Justice Atkin in Williams v.  
6 Guest" --- he had already said,  
7 and now he is quoting Atkin:

8 "It also has to be remembered that  
9 the cumulative effect of a series  
10 of accidents may still entitle the  
11 workman to compensation as in  
12 Salvage v. Burrell & Sons Ltd.,  
13 in which case the girl in the  
14 course of her employment contrac-  
15 ted in the course of four months  
16 a series of small cuts or abrasions  
17 the effect of which was to cause  
18 an incapacity and it was held that  
19 it was not necessary to be able  
20 to name and give evidence of the  
21 precise time at which the accident  
22 happened which had caused the  
23 incapacity."

24 And Mr. Justice Kerwin continues

25 "These matters/<sup>are</sup> referred to  
26 to indicate the necessity of taking  
27 into consideration the whole of the  
28 Act in coming to a conclusion as to  
29 whether in the circumstances of the  
30 present case the injury to the





1 Respondent was caused by accident.  
2 The history of the Act shows that  
3 the statute should be construed  
4 liberally in favour of all workmen  
5 within its purview. It is not  
6 possible to distinguish in time  
7 between the Respondent's actions  
8 of pulling the lever and the back  
9 injury she sustained and that  
10 injury, even though arising by  
11 reason of a series of operations  
12 of the machine should be held to  
13 have been caused by accident."

14 And the Court so held.  
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BL/SS 1 Finally, on that point, and with this I  
2 conclude, Mr. Commissioner, Mr. Justice Tysoe gave  
3 extensive consideration to this very problem. After  
4 reviewing the opinion of some doctors that they had  
5 difficulty in deciding whether a back injury was caused  
6 by employment or not, where there was nothing in the  
7 nature of a trauma to settle it in their minds, he said  
8 this at page 226 of his report, pages 226, 227:

9 "I cannot believe that, even  
10 applying medical theory alone, the  
11 development of a back disability  
12 can never be said to be work-  
13 connected in the absence of some-  
14 thing in the nature of an accident  
15 that triggers it."

16 And later on at page 227:

17 "Perhaps the difficulty will  
18 not be quite so great as the doctors  
19 suggest it is if the emphasis is  
20 placed on the 'reasonable proba-  
21 bility' of the disability being  
22 work-caused and not on the possi-  
23 bility of it being caused by  
24 gardening or golf, and if also the  
25 medical concepts are tempered with  
26 the common sense of laymen in the  
27 Claims Department. I find it  
28 impossible to convince myself that  
29 it is just to differentiate between  
30 two workmen who have performed the







1 same type of work for the same  
2 length of time and who end up  
3 with like disabilities simply  
4 because one of them can point  
5 to a tripping or slipping while  
6 the other cannot."

7 May I commend these statements to you, Mr. Commissioner,  
8 because I think the whole question of back injuries and  
9 serious back injuries is a very important one. They are  
10 in our impression on the increase, perhaps for some of the  
11 reasons already noted.

12 That brings me to the end of my  
13 submission, Mr. Commissioner. I should like on behalf of  
14 myself and my colleagues who are here to thank you for  
15 the manner in which you have heard us. We appreciate  
16 the opportunity of having appeared before you. Thank you.

17 THE COMMISSIONER: Mr. Estey may have  
18 some questions.

19 MR. ESTEY: While you are here, Mr.  
20 Ingle, I should like to ask you some questions which you  
21 and your colleagues may be able to answer to assist us in  
22 discharging the Commissioner's function under the terms  
23 of reference.

24 Before getting into some of the  
25 specifics raised by your brief and raised by your remarks,  
26 can you tell me how many industries under Schedule 2 to  
27 the Act your union represents?

28 MR. INGLE: No, I can't offhand. Mr.  
29 Storey draws my attention to the fact that probably ship-  
30 building would be the major industry where we have





1 collective agreements.

2 MR. ESTEY: Shipbuilding, you say?

3 MR. INGLE: Yes.

4 MR. ESTEY: The construction of boats,  
5 ships and vessels for the business of navigation?

6 MR. INGLE: Yes.

7 MR. ESTEY: Would that be in the  
8 Province of Ontario?

9 MR. INGLE: Yes, Collingwood and Port  
10 Arthur.

11 MR. ESTEY: The head of the lakes?

12 MR. INGLE: Yes.

13 MR. ESTEY: Do I take it the premise  
14 of your remarks with reference to the abolition or  
15 retention, as the case may be, of Schedule 2 is based on  
16 the presumption that there is some evidence to support  
17 your belief that it costs ~~more~~ to administer that  
18 section of the Act because there is a higher incidence  
19 of appeal and contest?

20 MR. INGLE: Yes.

21 MR. ESTEY: Is there anything else?

22 MR. INGLE: There is also the delay in  
23 processing claims under Schedule 2 for the same reason.

24 MR. ESTEY: Is it on the hypothesis that  
25 the evidence would indicate that there is a longer delay  
26 in getting compensation under Schedule 2 on the average  
27 than under Schedule 1?

28 MR. INGLE: Yes.

29 MR. ESTEY: I take it that the position  
30 of your union would be that if these two beliefs were





1 not supported by the Board's analysis of the facts you  
2 would have no other alternative under Schedule 2.

3 MR. INGLE: I still think it is a good  
4 idea for all employees to be covered under one schedule.

5 MR. ESTEY: That may be, but the Royal  
6 Commission cannot say this would be a good idea and leave  
7 it up in the air. I want to know why.

8 There is a third matter, and that is  
9 where an employee had a claim and it may be paid under  
10 Schedule 1, and that would be the end of it, but an  
11 employer may go broke and he cannot get it under Schedule  
12 2.

13 MR. INGLE: I cited two instances.

14 MR. ESTEY: ~~The~~ man got paid in those  
15 two instances.

16 MR. INGLE: He got paid ultimately. He  
17 did not get paid by the employer who had liability under  
18 Schedule 2.

19 MR. ESTEY: Those were 30 years ago.

20 MR. INGLE: Yes.

21 MR. ESTEY: We have had nothing, in  
22 other words, except two Royal Commissions on workmen's  
23 compensation.

24 MR. INGLE: Yes.

25 MR. ESTEY: On the question of the  
26 elimination of the waiting period, I take it what you  
27 are saying there is that you would like the waiting  
28 period reduced to one day and the man is compensated for  
29 the period after the one day has expired.

30 MR. INGLE: That is right.







1 MR. ESTEY: That is the nub of it?

2 MR. INGLE: Yes.

3 MR. ESTEY: So I take it you don't  
4 favour the procedure now of having two and a fraction  
5 days and the man gets paid from the day of the accident.  
6 You are dropping the day of the accident, but you are  
7 making it easier for the man to get his claim approved.  
8 Is that correct?

9 MR. INGLE: That is substantially  
10 correct, yes.

11 MR. ESTEY: Is there any advantage to  
12 saying that the man should not be paid for the day he is  
13 injured?

14 MR. INGLE: He is sometimes paid  
15 afterwards by the employer.

16 MR. ESTEY: Sometimes by direct payment,  
17 sometimes gratuitously?

18 MR. INGLE: Yes.

19 MR. ESTEY: You say that that day may  
20 not be so important because of trade practice, but what  
21 you say is important is the reduction from two and a  
22 fraction to zero..

23 MR. INGLE: That is correct.

24 MR. ESTEY: I take it you feel that there  
25 is no merit in the so-called deterrent of the deductible  
26 feature of this form of insurance of one or two days.

27 MR. INGLE: No.

28 MR. ESTEY: I take it that is a common  
29 feature in the insurance field, that there is discouragement  
30 of claims for the loss of a headlight, and so on,





1 in automobile claims.

2 MR. INGLE: Yes.

3 MR. STOREY: I think I should point out  
4 that in sickness and accident policies your insurance  
5 starts on the first day of the accident.

6 MR. ESTEY: I am just talking about the  
7 general deductible features being a deterrent, but that  
8 is not what you are saying.

9 MR. STOREY: No. If I am injured out  
10 shopping tonight I am covered immediately, there is no  
11 waiting period at all, as long as it is not covered under  
12 the Act.

13 MR. ESTEY: Is there much prevalence  
14 of the practice amongst workmen in the group you  
15 represent, which is considerable, of buying their own  
16 insurance in addition to the coverage they get under  
17 The Workmen's Compensation Act if they are injured at  
18 work?

19 MR. DOWLING: I have no knowledge of  
20 any.

21 MR. ESTEY: We have an illustration here  
22 of a complementary type.

23 MR. STOREY: The type of insurance I  
24 refer to is called sickness and accident, and it is  
25 designed to provide take-home pay of a certain amount  
26 where you are injured or off through sickness, which is  
27 not covered by The Workmen's Compensation Act. Most  
28 plans are group insurance plans, paid sometimes by the  
29 company completely, sometimes partly by the employee and  
30 the company, and these plans provide generally that they





1 will be paid the benefits when they are injured outside  
2 the plant for the first day.

3 MR. ESTEY: I take it you don't know of  
4 any group plans within your trade unions here where there  
5 are benefits which are payable with the exception of the  
6 case of The Workmen's Compensation Act type benefits?

7 MR. STOREY: I have never heard of any.

8 MR. INGLE: There are probably individuals  
9 who purchase insurance, but we have no knowledge of that.

10 MR. ESTEY: We have evidence that that  
11 is done, but I just wondered if you had any knowledge.

12 MR. INGLE: No.

13 ~~MR.~~ ESTEY: On this question of the  
14 ceiling, under the heading of Ceiling of Compensation,  
15 you have two ideas lumped together here and they are  
16 related, and I think I could fairly summarize it by  
17 saying that the first idea is that the wage ceiling is  
18 wholly arbitrary and has no logic.

19 MR. INGLE: That is right.

20 MR. ESTEY: And the second thing you are  
21 objecting to is that in addition to putting a ceiling  
22 on the arithmetical base, the statute also eliminates  
23 from compensable features everything except earnings.

24 MR. INGLE: That is right.

25 MR. ESTEY: Section 41 even goes further  
26 than that and says that you may eliminate compensation  
27 without regard to earnings if a man could earn.

28 MR. INGLE: Yes.

29 MR. ESTEY: So the Act is inconsistent.

30 MR. INGLE: Under Section 41, yes.







1 MR. ESTEY: It is someone's opinion  
2 whether he could do it.

3 MR. INGLE: Yes.

4 MR. ESTEY: So you say the Act fails on  
5 grounds of fundamentals. Firstly, it isn't a true  
6 insurance scheme because he doesn't get compensated for  
7 all the things he should get compensated for as in  
8 common law, and also it is subject to disability, either  
9 totally or partially.

10 MR. INGLE: Yes.

11 MR. ESTEY: And there is the matter of  
12 going to court. There is also the security that he is  
13 going to get paid.

14 MR. INGLE: I am not sure whether you are  
15 asking me this. We are not suggesting --- I want to make  
16 this very clear --- that the Act be changed so as to alter  
17 the restriction of people going to court. We don't want  
18 to advocate that at all. I haven't dwelt on that because  
19 I didn't think it was a very live issue.

20 MR. ESTEY: It has been raised, but not  
21 very seriously.

22 MR. INGLE: It seems to me that employees  
23 and employers alike have a great stake in maintaining  
24 that particular feature.

25 MR. ESTEY: Maintaining the insurance  
26 concept?

27 MR. INGLE: At least keeping these cases  
28 out of the courts.

29 MR. ESTEY: Which amounts to a collective  
30 insurance concept.





1 MR. INGLE: That is right.

2 MR. ESTEY: And I am putting it to you  
3 that one reason why you have to balance your loss of  
4 compensation for disfigurement, for example, you have to  
5 balance that universal sharing of the risk, and I suppose  
6 that is why the Act reduces it to terms of wages.

7 MR. INGLE: This may not be true, but I  
8 think it is, that there have been a number of suggestions  
9 and a great many Royal Commissions, Mr. Justice Roach  
10 and others, and I notice in some of the briefs submitted  
11 to this Commission, including the one of the International  
12 Nickel Company, that there should be some contribution by  
13 the workmen, as that is used in the Act, to the successful  
14 operation of the scheme.

15 MR. ESTEY: This comes from many sources,  
16 Chief Justice Meredith, Middleton.

17 MR. INGLE: Yes. I strongly disagree with  
18 that concept. I see no reason why there should be any  
19 contribution from the individual workman to his proper  
20 compensation for injuries that he received during his  
21 employment. I don't see why he should have to make a  
22 contribution. He may run into difficulties when he had no  
23 protection; he may have to go to court to get protection.  
24 I think it is a non sequitur, that he should therefore  
25 make some contribution.

26 MR. ESTEY: Does your group believe, in  
27 these sixteen or seventeen proposals you have put forward,  
28 that if the burden is at least too great to place on some  
29 industries, either the workmen contribute as they do in  
30 some types of plans we see these days, or it should be





1 paid out of the consolidated revenue of the government?

2 MR. INGLE: If there are some such  
3 industries, and it seems to me that they are not  
4 economic operations, it seems to me that the public to  
5 that extent is subsidizing that industry.

6 MR. ESTEY: You mean the rest of the  
7 employers are subsidizing it? What are your proposals  
8 as to where the money comes from?

9 MR. INGLE: It seems to me that the  
10 industries of this province should be required to pay the  
11 full costs of the compensation for their employees, and  
12 if they cannot do that, then it seems to me that they are  
13 uneconomic operations.

14 MR. ESTEY: One of the points was that  
15 the workman should not lose his entitlement, and that  
16 was one of the origins for the statement that the workman  
17 should make a contribution. My question is: if you  
18 eliminate all of these things historically called the  
19 workman's contribution and the cost is too great for  
20 industry, I want to know from your viewpoint where the  
21 money is to come from. Is there to be some assessment  
22 against the workman or should it come from the employer,  
23 or where?

24 MR. INGLE: If we had to face that  
25 situation, then in my opinion it should come from the  
26 government. We should hope that that situation would not  
27 arise, that the full cost would be borne by industry.

28 MR. ESTEY: What about pensions which  
29 may be 25, 30 years old, and the employer is long out of  
30 business and, in fact, maybe the whole class of industry







1 is out of business? Perhaps it is the old horse-and-  
2 buggy days. Now, who pays for that increase in assessment?  
3 The government generally or the nearest type of employer  
4 or employers generally?

5 MR. INGLE: I realize there may be  
6 inequities in that type of situation, but I draw your  
7 attention to this, that there are also many industries  
8 which have, over the years, contributed their assessment  
9 to the Workmen's Compensation Fund and which never had  
10 accidents. They made these contributions and they never  
11 had any of their employees injured, and the system may  
12 perhaps have been said to have inequitable assessments,  
13 as far as those people are concerned.

14 MR. ESTEY: You average it out in the  
15 concept of insurance.

16 MR. INGLE: Yes. That contribution is  
17 for current purposes. I understand that, with the  
18 exception of some exceptional ones, ordinarily the  
19 current assessment is to take care of current disburse-  
20 ments by the Board, including amounts they have had to  
21 set up in their reserve fund.

22 MR. ESTEY: That reserve in the fund to  
23 take care of future pensions.

24 MR. INGLE: Yes.

25 MR. ESTEY: So when you talk about  
26 people who contributed and who didn't have accidents,  
27 that was just in connection with that particular idea.  
28 The current industry would not be involved there.

29 MR. INGLE: No. I was just answering the  
30 question with respect to employers who had accidents and





1 then who are out of business. There may, of course, be  
2 current employers who are paying compensation and who  
3 have good accident records and they contribute to an  
4 insurance.

5 MR. ESTEY: We have heard from them.

6 MR. INGLE: Yes. They don't want to pay.

7 MR. ESTEY: To some extent the same  
8 thing applies when they get to the level where a workman  
9 is injured by his own negligence and gets compensation,  
10 and a workman who is not injured through his own  
11 negligence is cut down to 75 percent. The concept of  
12 the Act originally was this business of sharing the  
13 risks and sharing the benefits, and some people as a  
14 consequence do better and some do worse.

15 MR. INGLE: That is right. I suggest,  
16 however, that the individual who is injured, his injury  
17 in a sense is making a very major contribution. This is  
18 one of the things he has to suffer. As I indicated in  
19 various places in the brief, there are other things which  
20 the injured person loses.

21 MR. ESTEY: He sacrifices his right to  
22 sue.

23 MR. INGLE: Not only that, but he loses  
24 a chance of promotion, advancement. If he is permanently  
25 totally disabled he loses all the opportunity for useful  
26 occupations. There are many things which such a person  
27 loses. I am not too concerned about his contribution;  
28 it seems to me that he has made it.

29 MR. ESTEY: Your comments on Section 9  
30 relate to that. Section 9 says that if a workman is





1 injured in the course of his employment he may still bring  
2 an action.

3 MR. INGLE: Yes.

4 MR. ESTEY: And he may elect to go  
5 against the fund or he may not. In Section 9 (2) it  
6 also adds that as a result of that, if the workman goes  
7 after the person who caused the injury but he gets less  
8 than what he is asking, he can get it out of the fund.

9 MR. INGLE: Yes.

10 MR. ESTEY: And if there is excess  
11 recovered, then the excess should be recovered against  
12 the employer.

13 MR. INGLE: We see no reason why in every  
14 case, not just the subrogated cases, but in every case,  
15 he should not be compensated for pain and suffering.

16 MR. ESTEY: Your proposal in 9 is to  
17 expand subsection (2) to include the other side of the  
18 coin. 9 (2) says that if he gets less he can recover it  
19 out of the fund, but if someone using his name recovers  
20 more, then he is entitled to that.

21 MR. INGLE: Yes.

22 MR. ESTEY: And you say that nobody should  
23 profit from a workman's injury.

24 MR. INGLE: That is right.

25 MR. ESTEY: On this question of deafness,  
26 which is dealt with by Mr. Justice Middleton at pages 79  
27 to 83, and which you deal with, I think, in two different  
28 places, of course deafness is not found in our Schedule  
29 3, and your proposal is that that would not be entirely  
30 acceptable because it may give rise to difficulty as to







1 what is causing deafness and disease. What are your views  
2 on the concept of the British Columbia statute where they  
3 have added "traumatic deafness and any injury . . .  
4 middle ear".

5 MR. INGLE: They have also added "Occu=  
6 pational deafness --- Any industry involving prolonged  
7 and continued exposure to excessive noise." This wouldn't  
8 be in the category of industrial disease. I may be wrong.  
9 It is not a disease, it is an accident.

10 MR. ESTEY: The British Columbia Act  
11 has gone further.

12 MR. INGLE: The one that you have  
13 referred to, I think you will find, if you look at  
14 Schedule 3 of the B. C. Act --- and this is one of the  
15 difficulties of the B. C. Act which Mr. Justice Tysoe  
16 referred to ---- the original schedule, there are some  
17 fifteen or twanty industrial diseases which have been  
18 defined in the schedule by statute, and then there are  
19 all the others, including the one I think you have just  
20 mentioned, which have been added by the Board under the  
21 authority they have under Section ---

22 MR. ESTEY: 8 (2).

23 MR. INGLE: 8 (2) of their Act. The  
24 one I have referred to, if you look at page 147 -----

25 MR. ESTEY: The one you refer to is in  
26 the B. C. Act?

27 MR. INGLE: Yes --- they added on April  
28 the 14th.

29 MR. ESTEY: What are your comments about  
30 adding those to our statute?





1 MR. INGLE: It would be better than the  
2 situation we have now. I only commented that it seems to  
3 me that there is a logical difficulty, and perhaps a  
4 medical one, in calling something other than traumatic,  
5 in calling that a disease. If the Board will accept it  
6 and the doctors accept it, that is fine.

7 MR. ESTEY: Let's leave that wording to  
8 the doctors. I take it that the heart of your submission  
9 is that you would think it proper if we expanded the  
10 Ontario legislation to include deafness as they have it  
11 in British Columbia?

12 MR. INGLE: It would be a great  
13 improvement, Mr. Estey.

14 MR. ESTEY: I take it the same applies to  
15 disfigurement, that there are two or three different  
16 statutes which cover different kinds of disfigurement.

17 MR. INGLE: They are not limited to  
18 disfigurement, although it is specifically mentioned by  
19 the rules of interpretation as I understand them. Take  
20 Section 46 (4) of the Alberta Act.

21 MR. ESTEY: Yes, that is the one I am  
22 looking at.

23 MR. INGLE: "where a workman has been  
24 seriously and permanently disfigured about the face or  
25 head or otherwise permanently injured. . ."

26 MR. ESTEY: I take it from our rules of  
27 interpretation that the "otherwise permanently injured"  
28 would probably be confined to something about the face  
29 or head; but the other statutes I have referred to,  
30 particularly Section 28 (2) of the Manitoba Act, are not





1 so limited, that the amount that the workman was able to  
2 earn has not been substantially diminished; and it is  
3 also in the other Acts. The heart of these disfigurement  
4 provisions still seem to relate to earning power, and  
5 also there is the capacity to earn. I take it your  
6 submission is that the disfigurement, as you point out,  
7 in common law is compensable there, that there is an  
8 inferred loss of capacity to earn. I take it that is  
9 what you are proposing here.







3/SS 1 MR. INGLE: B. C.'s is 22 (2), I believe.  
2 MR. ESTEY: The B.C. Act recognizes  
3 impairment of earning capacity?  
4 MR. INGLE: Yes.  
5 MR. ESTEY: One other goes further than  
6 that and says if there is disfigurement you may be  
7 compensated.  
8 MR. INGLE: The B. C. Act instead of  
9 referring to "otherwise permanently injured" uses the  
10 term "permanently disfigured".  
11 MR. ESTEY: "about the face or head or  
12 otherwise".  
13 MR. INGLE: You are quite right, it  
14 narrows down the section.  
15 MR. ESTEY: I take it you prefer that  
16 one over the subjective test in the Alberta statute from  
17 your comments about our Section 41.  
18 MR. INGLE: Yes.  
19 MR. ESTEY: Now, Mr. Ingle, can I direct  
20 your mind to your section on page 10 on the matter of  
21 appeals. You unfortunately missed several days'  
22 discussion we had here on the appeal procedure, so I will  
23 move along rather quickly.  
24 MR. INGLE: I regret that.  
25 MR. ESTEY: I take it that your union has  
26 been and is currently party to a great number of appeals  
27 under The Workmen's Compensation Act.  
28 MR. INGLE: Yes.  
29 MR. ESTEY: Can you tell the Commissioner  
30 if this is a matter of announced union policy that if the





1 workman wishes the services of a representative of the  
2 union he may have it for an appeal, or how does it come  
3 about?

4 MR. INGLE: Here, Mr. Estey, I would like  
5 Mr. Dowling to deal with this part of it. He is much more  
6 familiar with appeals.

7 MR. ESTEY: Could you add to that question  
8 for me, Mr. Dowling, please?

9 MR. DOWLING: Well, we do have a policy  
10 where members of this union, having problems with  
11 Workmen's Compensation, starting at the Claims Department  
12 should they wish any assistance they generally write me  
13 a letter or other staff representatives besides myself  
14 on their behalf, and sometimes I have had to have this  
15 in writing from the claimant on instructions from the  
16 Board because others have perhaps gone before them before  
17 we ever heard the case --- and then either write a  
18 letter to the Board or phone them direct asking for  
19 specific information because the letters from the Board  
20 were not clear enough as to why the claim had been  
21 rejected.

22 MR. ESTEY: I just want to cover one  
23 thing at a time so we can move along here. I take it  
24 that the reason that the union represents the man on the  
25 appeal system regularly is that you have acquainted the  
26 working force with the availability of your service.

27 MR. DOWLING: That is right.

28 MR. ESTEY: And you take their case up  
29 at some stage and do you have to come to Toronto to appeal  
30 the Sudbury cases and Port Arthur cases where you mentioned





1 you have a work force?

2 MR. DOWLING: In some cases at the  
3 tribunal level we go to the area, for instance, Sault Ste.  
4 Marie or Port Arthur or notify Walter Johnson by mail.  
5 This is generally arranged between parties.

6 MR. ESTEY: Under the old system where  
7 this was not available where did you have to go to deal  
8 with the Board?

9 MR. DOWLING: Generally at the Board  
10 level.

11 MR. ESTEY: In Toronto?

12 MR. DOWLING: Either on University Avenue  
13 or Harbour Street since then.

14 MR. ESTEY: But in Toronto?

15 MR. DOWLING: In Toronto.

16 MR. ESTEY: But where you have a large  
17 force such as up in Sudbury, and I believe you were there  
18 prior to the 1965 appeal procedure ---

19 MR. DOWLING: Yes.

20 MR. ESTEY: ...you had to deal with  
21 those appeals by having your representatives in Toronto  
22 see the Board or the Sudbury people come down to the  
23 Board?

24 MR. DOWLING: That is right.

25 MR. ESTEY: Whereas I take it now one  
26 advantage of this appeal procedure is that the Board  
27 sits in Sudbury for this tribunal.

28 MR. DOWLING: That is right.

29 MR. ESTEY: So at least that is an  
30 advantage.







1 MR. DOWLING: That is an advantage as far  
2 as the geographical area is concerned, yes.

3 MR. ESTEY: I take it that under the old  
4 system prior to March, 1965 you did not know that the  
5 claim had been rejected until after the Review Committee  
6 had dealt with the matter.

7 MR. DOWLING: Well, no, the claim was  
8 rejected at the Claims Department.

9 MR. ESTEY: But did the man find out it  
10 was rejected then?

11 MR. DOWLING: Yes, the man found out and  
12 then he had the right of appealing to the Review  
13 Committee.

14 MR. ESTEY: We heard from the Board that  
15 that was not so and I just wondered on what you based  
16 that statement. The Board said there was a review  
17 automatically without a reference to the man and that he  
18 never did know the claim had been rejected until after  
19 the Review Committee also rejected it. Do you remember  
20 from your experience was that so?

21 MR. DOWLING: No.

22 MR. ESTEY: Or do you think it was the  
23 other way around?

24 MR. DOWLING: I think it is the other  
25 way around.

26 MR. ESTEY: Then after the Review  
27 Committee had turned the appeal down can you tell us from  
28 your experience, Mr. Dowling, was the man informed that  
29 he had the right of appeal to the whole Board?

30 MR. DOWLING: You are talking about a





1 Review Committee and it is not correct. It is the Review  
2 Board. The present system is a committee.

3 MR. ESTEY: The pre-1965 second stage.

4 MR. DOWLING Was a Review Board.

5 MR. ESTEY: After the pre-1965 second  
6 stage was the man informed by the Board that he had a  
7 right of appeal to the Board?

8 MR. DOWLING: Yes.

9 MR. ESTEY: We have heard that he was  
10 not. But you say in your recollection he was?

11 MR. DOWLING: Yes. I mean, he would be  
12 notified and in the instance of this I would sometimes  
13 get a copy of that decision from the Review Board. I  
14 appeared before the Board on his behalf.

15 MR. ESTEY: Were you told at the time  
16 that you were turned down by the review stage that you  
17 had a right of appeal?

18 MR. DOWLING: Yes, you have a right of  
19 appeal. I am told that.

20 MR. ESTEY: You were told that under the  
21 old system?

22 MR. DOWLING: Yes.

23 MR. ESTEY: The reason I dwell upon that  
24 is that the Board in describing the old system to us  
25 said that the man was not told he could go to the full  
26 Board. I just wanted your comment on that and I think  
27 you have given it to me.

28 MR. DOWLING: Well, I have been handling  
29 these claims and it could easily be obtained on the basis  
30 of a telephone call or a letter from the Board that the





1 man's case had been rejected and it followed in three  
2 stages, Claims Department, the Review Board and then to  
3 the top Board.

4 MR. ESTEY: You knew you had the right, so  
5 you didn't have to be told?

6 MR. DOWLING: That is right. I mean,  
7 this had been explained to us for years when we had  
8 educational programs by members of the Board, officers of  
9 the Board.

10 MR. ESTEY: And you were regularly  
11 appearing, so you knew the ropes?

12 MR. DOWLING: I knew the ropes, yes.

13 MR. ESTEY: In your preliminary discussions  
14 with the staff of the Board which is mentioned in your  
15 brief on page 10 and which you or Mr. Ingle told us  
16 about, were you shown in the pre-1965 period the medical  
17 report in full?

18 MR. DOWLING: No, I was not.

19 MR. ESTEY: Did you get a summary back in  
20 those days of what was in the medical report?

21 MR. DOWLING: No, I customarily listed a  
22 number of claims if it was on medical evidence and the  
23 large majority of the claims were rejected for medical  
24 reasons and I would visit the Board offices with one of  
25 the officers of the Board and he would read from some  
26 information he had available out of the files, the reason  
27 from an investigation if it was investigated by a  
28 member of the Review Committee or the Review Board at that  
29 time or the Review Committee at the present time and then  
30 I would, based on the information given to me, have a more







1 clear understanding of what the Board meant when they  
2 sent a letter. When they sent a letter of rejection all  
3 they had was "Rejected Claim", so I could then inform  
4 the claimant that his claim was rejected for these  
5 particular reasons and, as he had not sufficient further  
6 information or medical opinions on my basis of  
7 recommendation we could not proceed with anything further.  
8

9 MR. ESTEY: Just to break this down so  
10 we get along with it, you are saying that you did not get  
11 access to the full medical report in the old system and  
12 you don't now?

13 MR. DOWLING: Right.

14 MR. ESTEY: You get a summary now and I  
15 take it you used to get what amounted to a summary then?

16 MR. DOWLING: That is correct.

17 MR. ESTEY: So there has been no change

18 MR. DOWLING: No change in that.

19 MR. ESTEY: You say on page 11 of your  
20 brief that the claim is adjudicated by the claims  
21 officer without the benefit of any further medical  
22 information. If the claims officer thought he needed  
23 more medical information under this new system he has  
24 not got the flexibility of the old system, he can't go  
25 back and get it, is that what you are saying?  
26 You will see it in the second paragraph on page 11, the  
27 first sentence.

28 MR. DOWLING: Yes, that is correct. All  
29 he receives is a notice telling him his claim has been  
30 denied and advises him of his right to appeal.

MR. ESTEY: That is not what the sentence





1 is dealing with, though, Mr. Dowling. You are saying  
2 affirmatively that the claims adjudicating officer can't  
3 get further medical information: He must decide on the  
4 information he then has in the file. Now, what do you  
5 base that statement upon? The Board has indicated that  
6 is not so. We want to know what you base your statement  
7 upon and if it is correct.

8 MR.DOWLING: The fact is the Board has  
9 ~~the~~ information upon which it bases its decision and that  
10 is the medical information it has on file. On that  
11 basis all we get back is a reply that information on  
12 file indicates ----

13 MR. ESTEY: That you can't have your  
14 claim?

15 MR. DOWLING: That is right.

16 MR. ESTEY: All right, I just wondered  
17 if you can tell us why is it the Steelworkers' Union  
18 believes that the adjudication officer may not get  
19 further medical information.

20 MR. DOWLING: I don't think he is  
21 permitted.

22 MR. ESTEY: Someone has told you that?

23 MR. DOWLING: That is right.

24 MR. ESTEY: Then you go on to say that  
25 under the old system you could get more information  
26 introduced at that point because in practice and in fact  
27 you knew that the Board was in doubt about it and this  
28 was something that they would like you to help clear up  
29 for them.

30 MR. DOWLING: That is correct, it works





1 two ways.

2 MR. ESTEY: So you went back to what  
3 you called the Assistant to the Vice-Chairman.

4 MR. DOWLING: Right.

5 MR. ESTEY: Special Assistant or some  
6 such word to the Vice-Chairman. Was there any significance  
7 under that system of having those men under the Vice-  
8 Chairman instead of under the Chairman or under someone  
9 else?

10 MR. DOWLING: Well, I don't know, I mean  
11 their title was at that time as I understood it, Assistant  
12 to the Vice-Chairman. They were people who had worked  
13 very closely with the union movement in the sense of  
14 putting on educational programs which were conducted  
15 all over the province. We got to know them, visits with  
16 the Board and so on, so that in a degree we could go down  
17 there and discuss the problem with him and on the basis  
18 of information that was not disclosed in communications  
19 to the claimant or to myself get further information  
20 to support the Board's decision on a rejected claim.

21 MR. ESTEY: Supposing under that system  
22 of pre-1965 the employer wanted to do the same thing,  
23 could he go and see the same Assistant to the Vice-  
24 Chairman, do you know?

25 MR. DOWLING: I don't know.

26 THE COMMISSIONER: Mr. Estey, I don't  
27 know whether you are nearing the end of the work for  
28 today, or is there additional work after this?

29 MR. ESTEY: We were going to go on, Mr.  
30 Commissioner, with the next brief.







1 THE COMMISSIONER: In that event, let us  
2 adjourn now for five minutes.

3  
4 ---Short recess.

5  
6 MR. ESTEY: Mr. Ingle, I was moving along  
7 in your brief on appeals procedure and dealing with the  
8 scales of compensation. Have you given any consideration  
9 to what, if any, weight, credit or account should be  
10 taken in computing compensation under these statutes  
11 for payments under new statutes such as the Canada  
12 Pension Plan disability features?

13 MR. INGLE: Yes, I have, Mr. Estey.  
14 It seems to me to take the Canada Pension Plan particularly  
15 --- sorry this is not made clear in the brief --- it  
16 seems to me that this is a plan to which the man contri-  
17 butes. He pays for it.

18 MR. ESTEY: Just like any other  
19 insurance, just like his own insurance policy.

20 MR. INGLE: Yes, and it seems to me he  
21 is entitled to what he pays for in addition to anything  
22 else. Now, if he should be injured he not only should be  
23 compensated to the full extent of his injuries, but he  
24 should also receive in addition to that the additional  
25 pension he has himself paid for. I see no reason why his  
26 compensation should be reduced by the amount of the  
27 Canada Pension Plan or any other pension plan to which he  
28 contributes and which he has paid for. He has bought  
29 that.

30 MR. ESTEY: One of the unhappy results of





1 that line of reasoning is, of course, and we have heard  
2 this, the employer takes exactly the same stand and says,  
3 "That is something we paid for and we should get credit  
4 for it". That is why I asked the question.

5 MR. INGLE: The amount that is  
6 contributed by the employer in schemes of this kind is  
7 really part of the man's wages.

8 MR. ESTEY: The Canada Pension Plan?

9 MR. INGLE: The Canada Pension Plan.

10 MR. ESTEY: That is right, but that is  
11 arguable, isn't it?

12 MR. INGLE: It is not voluntary, that is  
13 true. It is part of the total compensation ---- that is  
14 not the right word, the total remuneration that the  
15 employer pays for this man's services.

16 MR. ESTEY: Except it is not counted for  
17 that purpose when you compute the payroll assessment  
18 under the Workmen's Compensation Act.

19 MR. INGLE: That is a question of  
20 assessment, and it seems to me that so far as the  
21 entitlement to both the Canada Pension Plan benefits and  
22 Workmen's Compensation in one the man contributes with  
23 his own contribution and a portion the employer  
24 contributes and the Workmen's Compensation is something  
25 to which he is entitled because he has suffered an  
26 injury.

27 MR. ESTEY: That is what I wanted to  
28 hear. Now, let us accept that as your view and it is,  
29 that this Canada Pension Plan disability payment is not  
30 something to be taken into account in re-designing the





1 Workmen's Compensation Act, that is your view. What is  
2 your view if the result of all that is that the man  
3 receives, say, 110 percent of his wages for being hurt?

4 MR. INGLE: I recognize that this  
5 possibility exists.

6 MR. ESTEY: What should the state then do?

7 MR. INGLE: The state would not have to  
8 do anything.

9 MR. ESTEY: It would have to do if you  
10 paid him 110 percent.

11 MR. INGLE: I don't think the state  
12 would have to do anything about that situation. It is  
13 the same as if a man has, it seems to me, it is similar  
14 to the situation where a man has a pension plan, at  
15 least a pension entitlement.

16 MR. ESTEY: I take it you don't think  
17 there should be a provision in the Workmen's Compensation  
18 Act to prevent that as there is in the Hospital Act.

19 MR. INGLE: I do not.

20 THE COMMISSIONER: In Great Britain they  
21 have done it by throwing it all in together and then  
22 restoring his right to sue.

23 MR. INGLE: I would not like to see that  
24 situation, Mr. Commissioner. We don't want to get back  
25 into the courts.

26 MR. ESTEY: Under the question of  
27 increasing disability payments you have seen the Board  
28 tables, I take it, as to the cost and I assume that you  
29 make your comments today in the light of your awareness  
30 of what is in those tables.







1 MR. INGLE: Yes.

2 MR. ESTEY: So I move on to this question  
3 of the floating base for the pension calculation, that is,  
4 the cost of living index where you key the pension to the  
5 cost of certain select items which go to make up the cost  
6 of living index. You put forward the British Columbia  
7 solution as a remedy to this situation or I so read your  
8 brief on page 17.

9 MR. INGLE: That is correct.

10 MR. ESTEY: Under the British Columbia  
11 statute which, of course, is not a statute but has the  
12 effect of a statute ---- it is an Order-in-Council which  
13 is authorized by a statute to amend the British Columbia  
14 Workmen's Compensation Act, I am sure you are familiar  
15 with that peculiarity ---- at page 283 of their Gazette  
16 it says:

17 "When the level of the consumers'  
18 price index for any year after the  
19 base (which is 1964) has increased  
20 by not less than two per centum  
21 over the level of the consumer  
22 price index for the base year the  
23 Board shall increase the periodical  
24 payment made to a workman...."

25 and so on.

26 "But this clause shall apply only  
27 to the first increase so made",

28 and then you go down to the next section and it says in  
29 effect that every year that this happens that there is a  
30 two percent increase or greater in the consumer price





1 index, then the pension theretofore granted by the Board  
2 shall be increased by two percent and that I take it is  
3 generally the plan which you think we might be wise to  
4 consider.

5 MR. INGLE: Yes.

6 MR. ESTEY: The consumer price index in  
7 that regulation is the index published by the Dominion  
8 Bureau of Statistics at the moment called the Consumer  
9 Price Index. I think the Order-in-Council says that it  
10 follows that index or anything in place thereof, and I  
11 take it you also recommend using the federal cost of  
12 living index as the basis for the cost of living adjusted  
13 income.

14 MR. INGLE: The Federal Consumer Price  
15 Index, yes.

16 MR. ESTEY: That is what the B. C. Act  
17 says.

18 MR. INGLE: Yes. I think they have  
19 discontinued using the term "Cost of Living Index".

20 MR. ESTEY: Yes. What is your view as to  
21 what happens if the consumer price index goes down either  
22 below the 100 or goes up and then returns to the 100,  
23 then what do we do?

24 MR. INGLE: Well, I should think as a  
25 result of the experience of a number of years now since  
26 the depression this is a most unlikely situation.

27 MR. ESTEY: Somebody made that statement  
28 just before the great depression, too.

29 MR. INGLE: The B. C. Act states, you may  
30 have read it and I am sure you have more carefully than I.





1 that there is no provision there for the reduction of what  
2 might be termed the cost of living bonus, but in the un-  
3 likely event that the cost of living index should go down,  
4 I am sure this was carefully considered by the British  
5 Columbia people when they adopted Section 22A. I still  
6 feel that this is a good step. It seems to me to run  
7 into difficulties if we tried to reduce the additional  
8 amount paid as a result of a reduction in the consumer  
9 price index. I know of no jurisdiction anywhere, there  
10 probably are some, where payments of this kind are tied  
11 to the cost of living formula and where there is  
12 provision for decreasing ---- old age pensions or any-  
13 thing else.

14 MR. ESTEY: I was just going to ask you  
15 about the famous one where the United Automobile Workers  
16 in 1947 entered into a collective agreement with this  
17 kind of a scheme and it had an upwards and downwards  
18 escalator and I was wondering if that was really what  
19 you are recommending or do you recommend the B. C.  
20 provision?

21 MR. INGLE: I think that it has been  
22 done away with.

23 MR. ESTEY: The whole contract has  
24 expired?

25 MR. INGLE: Yes, and that particular  
26 provision so far as I know has not been renewed.

27 MR. ESTEY: They have abandoned the B.C.  
28 type escalator also, but I was wondering if you are  
29 recommending a one-way escalator or a two-way escalator.

30 MR. STOREY: As I understand it, there







1 are quite a few collective agreements in this country, I  
2 believe including some U. A. W. contracts which have a  
3 one-way escalator; in other words, if the cost of living  
4 goes up a certain amount wages are adjusted, but should  
5 it fall, they remain at the high point.

6 MR. ESTEY: It works like the umbrella  
7 in the chimney, it can go up but never come down.

8 MR. STOREY: Right.

9 MR. INGLE: I also believe that in the  
10 U. A. W. contract that you referred to there was in fact  
11 no decrease in the cost of living during the length of  
12 that agreement so they did not face the question of what  
13 would happen if there was a decrease.

14 MR. ESTEY: As a matter of fact, as a  
15 footnote of history the whole thing was withdrawn in the  
16 next collective agreement.

17 MR. INGLE: That is right.

18 MR. ESTEY: In any event, you are saying  
19 that this Royal Commission should examine the B. C.  
20 provision with a view to putting it in the Ontario Act?

21 MR. INGLE: That is our recommendation,  
22 Mr. Estey.

23 MR. ESTEY: Bearing in mind that there is  
24 an inflationary element built into the pension liability  
25 of employers, is it your view that the fund available under  
26 Schedule 1 to pay for this should also authorize  
27 investments in fluctuating entities such as common stocks?

28 MR. INGLE: We have no submission to make  
29 on this, Mr. Estey.

30 MR. ESTEY: You have no objection to that  
proposal?





1 MR. INGLE: I just have no comment to  
2 make on it. I have not really studied it and so far as I  
3 know none of our officers have studied this particular  
4 question. I don't know what the indications are.

5 MR. ESTEY: You realize the reason I  
6 have put the question to you is the liability is keyed to  
7 the cost of living and I am wondering whether the fund  
8 to cover the liability should not also be keyed to the  
9 cost of living.

10 MR. INGLE: There may be advantages to  
11 this, I don't know that.

12 MR. ESTEY: You can see that the  
13 disadvantage of not so keying it is that future  
14 employers are saddled with an obligation of the old  
15 employers.

16 MR. INGLE: Yes.

17 MR. ESTEY: The employer pool is a  
18 dynamic entity, it is not a static entity, it is not  
19 the state.

20 MR. INGLE: I am sorry I cannot comment  
21 on that.

22 MR. ESTEY: Just one quick question on  
23 page 17, Mr. Ingle, down near the bottom. I am not sure  
24 I understand that sentence. It says that the pension  
25 to the employer will cost him in 1966 only \$82.71. I  
26 take it that the reason for that is that that is the  
27 amortized payment he makes in any given year for the  
28 obligation which was \$100.00 back in 1956, is that the  
29 explanation?

30 MR. INGLE: Yes.

MR. ESTEY: This is on the theory that





1 you don't fund the pension the day it is incurred, but  
2 you pay it off annually from then on.

3 MR. INGLE: Yes.

4 MR. ESTEY: On your temporary disability  
5 on page 19 this gets us into a field which is a little  
6 tricky, the interlocking of Workmen's Compensation and  
7 Unemployment Insurance. You say in the middle of  
8 paragraph (c) on page 19:

9 "He is not eligible to receive  
10 any unemployment insurance" ---

11 Now, we have heard the contrary from the Commission to  
12 the effect that he is eligible to receive Unemployment  
13 Insurance if he is capable of doing some work and has  
14 made himself available for that kind of work and the work  
15 is not available. Have you any understanding of that?

16 MR. INGLE: Yes.

17 MR. ESTEY: It works out to the man's  
18 disadvantage in some cases because the Commission, in  
19 effect, asks the man to scale down his value to the  
20 employing community while that temporary disability is  
21 in existence and some people won't do it and so they  
22 don't get the Unemployment Insurance.

23 MR. INGLE: He would only be eligible,  
24 though, for a job which was within his physical capacity.

25 MR. ESTEY: That is right, but his  
26 Unemployment Insurance would only come if there were no  
27 jobs of that calibre available.

28 MR. INGLE: That is correct, and I think  
29 that this is the most common situation. Perhaps that  
30 statement, as you draw it to my attention now, perhaps







1 goes farther than it should have gone.

2 MR. ESTEY: In principle your submission  
3 is, however, that in most cases the man is in fact unable  
4 to get work which will compensate him as he was  
5 accustomed to being compensated before he was hurt and  
6 therefore he should get for the temporary partial  
7 disability the same payment as he gets for total, that  
8 is your submission?

9 MR. INGLE: Yes.

10 MR. ESTEY: Your recommendation with  
11 respect to the widows' entitlement raises a question,  
12 Mr. Ingle. She would receive 75 percent of the  
13 employee's earnings under your proposal which would be  
14 the same as though the man had survived but was a total  
15 disability case, I take it?

16 MR. INGLE: Yes.

17 MR. ESTEY: But wouldn't there be some  
18 saving in not having the husband around? I am talking  
19 about financial savings. That would put profit into  
20 injury, wouldn't it?

21 MR. INGLE: Well, 25 percent we have  
22 agreed is his worth.

23 MR. ESTEY: I see, it didn't seem right  
24 to me if the man is worth anything and he gets the same  
25 compensation either dead or alive, that kind of hurt my  
26 pride.

27 MR. INGLE: We have recognized that he  
28 is worth at least 25 percent of his total earnings.

29 MR. ESTEY: On the limitation of earnings,  
30 the \$6,000 ceiling, do you have any views on the





1 suggestion made in one or two places including British  
2 Columbia that the ceiling should move upwards when a  
3 certain percentage of the people covered by the Act have  
4 earnings in excess of the old ceiling? Do you think that  
5 is a workable device?

6 MR. INGLE: Yes, I read with some interest  
7 Mr. Justice Tysoe's comments on this and his recommenda-  
8 tions.

9 MR. ESTEY: 45 percent.

10 MR. INGLE: Subject to the basic  
11 proposition which we have made that this limitation should  
12 be eliminated altogether I think that the scheme he has  
13 proposed --- and I don't know about the percentage, it  
14 seems to me that 45 percent is pretty high --- that this  
15 would be a big improvement over what we have got now  
16 which is nothing so far as moving that ceiling upwards  
17 as wage levels go up is concerned.

18 MR. ESTEY: It is arbitrary and it is  
19 permanent until someone repeals that part of the Act.

20 MR. INGLE: That is right.

21 MR. ESTEY: You would like some rolling  
22 device which would allow that ceiling to move with  
23 realities.

24 MR. INGLE: That would be a great  
25 improvement over what we have now. We would like to see  
26 the ceiling removed altogether because I can see no  
27 reason for the ceiling other than to save employers this  
28 part of the cost.

29 MR. ESTEY: I suppose one reason for that  
30 ceiling is that Workmen's Compensation like most other





1 insurance schemes is not designed to solve in money all  
2 problems, but rather to create a social floor below  
3 which a family or a worker will not fall and that is the  
4 reason for the ceiling, I take it, but you would rather  
5 have no ceiling and the second alternative would be an  
6 automatically adjustable ceiling.

7 MR. INGLE: Well, the social floor, as  
8 you describe it, Mr. Estey, then implies that the  
9 legislation is to some extent, I suppose, social welfare.

10 It is our feeling that this Act should be regarded as to  
11 whether it  
12 adequately compensates workmen for their injuries rather  
13 than provide something which is a social welfare measure.

14 MR. ESTEY: On this subject of accident  
15 prevention, Mr. Ingle, we are going to get into that  
16 more in depth next week, and it may well be that you  
17 will be able to return for part of that week, but I  
18 would like to ask you one general question, though,  
19 before we have gotten into it with other people. Do I  
20 understand the Steelworkers' view on this whole business  
21 is that the establishment of safety standards by  
22 regulation and the enforcement of the regulations and  
23 the research in connection with safety and with  
24 accidents and the linkage of accidents to working  
25 conditions should all be in one authority and that  
26 authority should be the Workmen's Compensation Board?

27 MR. INGLE: That is correct.

28 MR. ESTEY: And all we find now in the  
29 Department of Labour should be concentrated into this  
30 section of the Workmen's Compensation Board?

MR. INGLE: That is right.







1 MR. ESTEY: Do I understand you to also  
2 say that the cost of administering that vast collection  
3 of regulations --- and it fills a whole looseleaf book  
4 we have discovered --- should be borne by the Board which  
5 in turn is paid by the employers or should there be an  
6 assessment by the Board against the consolidated revenues  
7 of the Province of Ontario to pay for the statutory  
8 enforcement, the establishment of regulations under the  
9 statute and the enforcement of those regulations?

10 MR. INGLE: No, it is my opinion that ---  
11 and I am now expressing a personal opinion --- that if  
12 this were done, if this recommendation that we have made  
13 were accepted, then it seems to me that this is properly  
14 a charge against the general revenue of the province  
15 rather than against the individual employers. It seems  
16 to me we are now moving away from compensation per se and  
17 into something else and the Board would have a payment  
18 made to it from the consolidated revenue fund to meet  
19 that particular cost.

20 MR. ESTEY: And I take it you say also  
21 they should similarly be concentrated in this one  
22 authority dealing with industrial accidents and  
23 industrial conditions the type of work now being carried  
24 on by the Research Unit of the Department of Health? I  
25 have given it the wrong name.

26 MR. INGLE: Well, it is the Environmental  
27 Health Division, I think, of the Department.

28 MR. ESTEY: Environmental Health Branch  
29 of the Department of Health?

30 MR. INGLE: That is right.





1 MR. ESTEY: That should be concentrated  
2 in this new authority?

3 MR. INGLE: Well, I don't want to mislead  
4 you on this, but there is some work now being done by the  
5 Environmental Health Branch which is not stricly  
6 industrial hygiene at all, but is concerned with aspects  
7 of, for example, pollution and so on. That is the reason  
8 indeed, I am informed, that the name was changed from  
9 Industrial Hygiene to Environmental Health. It is only  
10 those aspects of that branch which are concerned with  
11 what was formerly Industrial Hygiene that I suggest  
12 should be transferred to the Board.

13 MR. ESTEY: That in British Columbia is  
14 the fact, that is the way this kind of work is being done  
15 in B. C., and that is what you are proposing?

16 MR. INGLE: Exactly.

17 MR. ESTEY: Then I take it that it  
18 follows that once you constitute such a new and  
19 centralized authority that you then don't care where the  
20 various sources of statutory authority are found, whether  
21 it be the Mining Act or the Health Act or the Workmen's  
22 Compensation Act or the Department of Labour Act or some  
23 other statute so long as it does, as we see in the  
24 Mining Act, give the power to the Workmen's Compensation  
25 Board.

26 MR. INGLE: Exactly, it would be the one  
27 body having jurisdiction, and in the case of the examina-  
28 tions made under the Mining Act which we were discussing  
29 with the Commissioner earlier, the provisions of 167, we  
30 have the same authority ---- appointing the doctors and





1 exercise control over them and so on.

2 MR. ESTEY: It is convenient, I take it  
3 now, to put it in the Mining Act so someone running a  
4 mine would be able to look in the Mining Act and know all  
5 his problems, but your real meaning is not where that is  
6 catalogued by the government, but who has the power.

7 MR. INGLE: Well, I am not advocating  
8 that jurisdiction over mines as such be transferred to  
9 the Workmen's Compensation Board, but those sections of  
10 the Mining Act which relate to compensation.

11 THE COMMISSIONER: While we are on this  
12 safety and accident prevention you have referred to the  
13 recommendations made several years ago in connection with  
14 the inquiry into accident prevention by Judge McAndrew  
15 and also to what was said by Mr. Justice Roach about the  
16 desirability of having representatives of labour on these  
17 industrial safety associations.

18 MR. INGLE: Yes.

19 THE COMMISSIONER: I realize that in the  
20 executive end or the overall safety association, take your  
21 own --- what is it called? What deals with the mining  
22 industry?

23 MR. INGLE: Mines Accident Prevention  
24 Association.

25 THE COMMISSIONER: Well, coming down to  
26 the mine itself, to the mine at Sudbury or International  
27 Nickel or whoever it may be, at any level are there labour  
28 representatives on safety committees?

29 MR. INGLE: I will have to ask Mr. Hickey  
30 this. Not so far as I am aware.







1 THE COMMISSIONER: Coming down to the  
2 International Nickel Mine, are there any labour  
3 representatives on safety committees in the mine at any  
4 level?

5 MR. HICKEY: No, sir, except in the union  
6 itself which has instituted safety committees who have a  
7 function in carrying complaints in regard to violations  
8 of safety to the attention of the management who then  
9 proceed to hear what the committee have to say and the  
10 matter as to whether corrections are made is done and if  
11 it is not done, it is referred on to a further meeting  
12 between that committee and higher management.

13 THE COMMISSIONER: In other words, then,  
14 at no level ---- I suppose that there is one organization  
15 that works out of this place over on Victoria Street and  
16 then it comes down to the individual mines, but in the  
17 individual mines I suppose there is some sort of a  
18 subordinate committee working in each mine. But you say  
19 there is no labour representation on that committee.

20 MR. HICKEY: No labour representation at  
21 all, sir.

22 THE COMMISSIONER: At any stage?

23 MR. HICKEY: At any stage. The only factor  
24 is that in the contract bargaining agreement there is a  
25 clause which recognizes the fact that employees may form a  
26 safety committee who may bring matters of safety to the  
27 attention of management for correction. Whether they  
28 correct it or don't correct, that is their decision.

29 THE COMMISSIONER: That is in your  
30 collective agreement?





1 MR. HICKEY: That is in the collective  
2 agreement.

3 THE COMMISSIONER: Thank you.

4 MR. ESTEY: I take it that only gives  
5 them the right to raise the problem, they just have a kind  
6 of advisory capacity?

7 MR. HICKEY: They only have the right to  
8 raise the issue, that is all.

9 MR. ESTEY: That may not be in the next  
10 collective agreement, so you have no security of that.

11 MR. HICKEY: There is no security of  
12 tenure in terms of that.

13 MR. ESTEY: Turning now to the question  
14 of your comments about International Nickel's points, they  
15 have raised I just have one or two points. One of them is  
16 one of the cases raised, one of those big long numbers,  
17 dealt with this question of partial disability, temporary  
18 total and temporary partial disability. Was ~~that~~ case  
19 appealed? It was C-6805245.

20 MR. HICKEY: No, sir, it was not  
21 appealed.

22 MR. ESTEY: Right.

23 MR. HICKEY: It was probably too recent  
24 to appeal.

25 MR. ESTEY: Out of this long history of back injury  
26 the Mine, Mill & Smelter, Mr. Kennedy, I think, said  
27 that one explanation for the rather sharp increase in  
28 back injuries reported in the International Nickel  
29 Mines was the increase in the age level of the miners.  
30 Is that, do you think, a factor?





1 MR. INGLE: Again I will have to call on  
2 Mr. Hickey.

3 MR. HICKEY: Presumably it would be a  
4 factor that would have to be taken into consideration.

5 MR. ESTEY: Do you think that it is a  
6 factor that has been concerned in back injury claims?

7 MR. HICKEY: In terms of actual back  
8 injury claims alone. It is very difficult to say unless  
9 an assessment is made of every accident that has taken  
10 place to see how old they were.

11 MR. ESTEY: The Steelworkers have no  
12 analysis of that at the moment?

13 MR. HICKEY: I think from my own  
14 experience I think there are more back injuries around  
15 about, say, 33, 34 and 35 and up than there are, say, at  
16 21 and 22 years of age.

17 MR. ESTEY: Do you think the age level  
18 of the mining bargaining unit has increased in the last  
19 fifteen years?

20 MR. HICKEY: Well, I have not seen any  
21 figures recently, but in 1963 we were given an indication  
22 that the average age at that time was 28, but you must  
23 take into consideration that at that time there were a  
24 number of factors that brought that level down to that  
25 low figure.

26  
27  
28  
29  
30







EL/SS 1 In terms of previous years, it has been as high as the  
2 average age of people who were injured. The figure was  
3 up around 41. The average was about 41 for the industry.

4 MR. ESTEY: That would indicate that the  
5 age level might be dropping.

6 MR. HICKEY: In view of the number of  
7 men who were in the lower age bracket.

8 MR. ESTEY: This would tend to bring the  
9 figures down, and probably temporarily, because of the  
10 employment payroll expanding, but you would have a  
11 greater number of people with seniority. Is that the  
12 situation?

13 MR. HICKEY: That is right.

14 MR. ESTEY: Mr. Hickey, perhaps you are  
15 the man I should ask this question of, and then we are  
16 finished. We heard some discussion of this leyner  
17 machine, and it is a newer version of drilling 27 holes  
18 at the face of the mine, and I think it was 2,000 men  
19 on the International payroll operate this drill.

20 MR. HICKEY: That would be my estimate  
21 of the number involved.

22 MR. ESTEY: And this would be out of  
23 a work force of about 15,000?

24 MR. HICKEY: Yes.

25 MR. ESTEY: That would be about one in  
26 eight who operate that drill.

27 MR. HICKEY: Yes.

28 MR. ESTEY: Is it a drill where you blow  
29 the face off?

30 MR. HICKEY: Did you say a casing





1 drill?

2 MR. ESTEY: You put an explosive in and  
3 blow the face off the wall?

4 MR. HICKEY: Yes.

5 MR. ESTEY: Let's examine the other side  
6 of the coin. Have there been any labour-saving machines  
7 installed in the International Nickel mine to allow the  
8 other 14,000 to do less heavy work than they used to?

9 MR. HICKEY: In actual practice there is  
10 less hard physical labour in terms of physical shovelling,  
11 the number who would be employed in that classification.

12 MR. ESTEY: How many people would be in  
13 that classification out of 16,000, would you say? Would  
14 it be more than one in eight?

15 MR. HICKEY: Including all the mines and  
16 the smelters, there were approximately 2,000 in that  
17 bracket, but that would be spread out now amongst the  
18 smelters, and I think probably that is about 5,000 men,  
19 and the mines which have about 8,000 men, and then Port  
20 Colborne which has about 1,800 men. So exactly how they  
21 are distributed I wouldn't be able to tell you.

22 MR. ESTEY: Thank you, Mr. Hickey. Thank  
23 you, gentlemen.

24 Mr. Commissioner, I was asked by two  
25 organizations to have their time fixed for some other  
26 time than this afternoon. One of them is the Ontario  
27 Professional Fire Fighters. Is there anyone else who  
28 does not wish to be heard, otherwise I will take them in  
29 the order we have them? The information provided as a  
30 result of phone enquiry is that the Ontario Federation





1 of Labour will not be available because of another hearing  
2 until Thursday morning. International Nickel: has  
3 International Nickel any comments on the items for this  
4 week, silicosis, pre-existing conditions, and so on?

5 MR. OSLER: We did have part of our  
6 brief on that, but if I want to comment on it it might be  
7 when I have this other statistical information.

8 MR. ESTEY: The International Union of  
9 Mine, Mill and Smelter Workers.

10 MR. KENNEDY: Our submission on this  
11 question will be quite lengthy and detailed. I would  
12 prefer to be heard tomorrow morning, or tomorrow some time  
13 at your convenience.

14 MR. ESTEY: The Labourers' International.  
15 I think Mr. Koskie spoke about that, Mr. Commissioner.  
16 The United Electrical Workers we have scheduled for  
17 tomorrow, Mr. Commissioner; the medical men, the  
18 Professional Fire Fighters, the Ontario Federation of  
19 Labour on Thursday.

20 If there are no others who wish to speak  
21 on this subject today, then perhaps we could have Mr.  
22 Kerr, Mr. Commissioner, deal with the chiropodists'  
23 submission this morning. I think he has some remarks in  
24 connection with their brief.

25 MR. KERR: I believe the gentlemen this  
26 morning representing the Ontario Podiatry Association  
27 indicated that they could only treat workmen's compensation  
28 cases for six weeks, following which the workman has to  
29 be referred to a doctor. I have checked with our Director  
30 of Medical Services, and I am advised that there are very







1 few workmen coming under The Workmen's Compensation Act  
2 who are treated by chiropodists because there are so very  
3 few chiropodists in Ontario. However, those who do treat  
4 workmen's compensation cases are not restricted to a six-  
5 week time limit. As their reports come into the office  
6 they are reviewed and the workmen are referred for  
7 examination only when it is felt necessary by the man's  
8 condition. There is no provision for treatment by  
9 chiropodists for workmen's compensation cases because  
10 there are so few of them.

11 THE COMMISSIONER: There is no published  
12 regulation as to the necessity for periodic review?

13 MR. KERR: There is no provision for a  
14 periodic review for patients treated by chiropodists.

15 THE COMMISSIONER: Is there any general  
16 regulation as to periodic intervals where reports are  
17 made or review is made by your own medical department?

18 MR. KERR: Just one, sir. That applies  
19 to the chiropractors and osteopaths.

20 THE COMMISSIONER: Where is that?

21 MR. KERR: It is outlined in the schedule,  
22 and at the end of 17 days they contact the Board for  
23 permission to continue treatment.

24 THE COMMISSIONER: Does this specify  
25 chiropractors and osteopaths?

26 MR. KERR: It specifies chiropractors,  
27 sir.

28 THE COMMISSIONER: It doesn't apply to  
29 the chiropodists?

30 MR. KERR: That is right, sir.





1 THE COMMISSIONER: You allow them on  
2 their progress reports to proceed without any medical  
3 examination?

4 MR. KERR: Yes, if it is necessary they  
5 will be contacted by one of our medical officers for any  
6 treatment or examination that is necessary.

7 THE COMMISSIONER: You reserve the right  
8 to exercise your right at any time?

9 MR. KERR: As we do in all cases for  
10 any practitioner, sir.

11 THE COMMISSIONER: Thank you.

12 MR. ESTEY: Thank you, Mr. Kerr.

13 That, Mr. Commissioner, completes the  
14 schedule for today. Tomorrow we have the medical briefs  
15 to which I referred, plus Mr. Kennedy's submissions, and  
16 I believe also two or three others who have indicated  
17 they are going to attend.

18 THE COMMISSIONER: We will adjourn until  
19 tomorrow morning.

20  
21  
22  
23  
24  
25 ---Adjournment.  
26  
27  
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PROVINCE OF ONTARIO

ROYAL COMMISSION

ON

THE WORKMEN'S COMPENSATION ACT

HEARINGS HELD AT  
TORONTO, ONTARIO

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IN THE MATTER OF The Public Inquiries  
Act, R.S.C., 1960, Ch. 227

IN THE MATTER OF an Inquiry Into and  
Report Upon The Workmen's Compensation  
Act

BEFORE: The Honourable Mr. Justice W. J.  
McGillivray, Commissioner, at  
Room 200, 67 Richmond Street  
West, Toronto, Ontario, on  
Tuesday October 18, 1966

APPEARANCES:

W.Z. Estey Q.C.)  
and ) Counsel to the Commission  
H.D. Guthrie )

G. A. Johnston Secretary

ALSO PRESENT:

Dr. J. N. Swanson

W. Kennedy and) International Union of Mine,  
W. E. Hall and) Mill and Smelter Workers  
N. Thibault )

Dr. R. B. Sutherland Ontario Department of Health

Dr. A. B. Powell and )  
Dr. F. H. VanNostrand) Workmen's Compensation Board

E. Mothersall and G.) Provincial Federation of  
Ireland ) Ontario Professional Fire Fighters

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11	22	Summary and Conclusions made by Dr. Mastromatteo published in Archives of Industrial Health, September 1959	1762
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EDIT

Volume 9

Page 1247, line 1: "drawn" should be "withdrawn"

Page 1243, lines 10 and 11 should read:

"Have in mind the other provisions  
that exist on Incentive Plans"

\*\*\*\*\*







1 ---On commencing at 10:00 A.M.

2  
3 MR. GUTHRIE: Mr. Commissioner, ~~Mr. Guthrie~~  
4 on the agenda for this morning two doctors, Dr. J.N.  
5 Swanson and Dr. R.B. Sutherland of the Department of  
6 Health, and also the brief of the International Union  
7 of Mine, Mill & Smelter Workers. I believe that it  
8 would be convenient to Dr. Swanson if we were to hear  
9 his evidence first, if that meets with your approval.

10 THE COMMISSIONER: Very well.

11 DR. J. N. SWANSON

12  
13 DR. SWANSON: I must apologize for having  
14 a cold. If I don't talk loud enough, please let me  
15 know.

16 MR. GUTHRIE: Doctor, perhaps you would  
17 begin by telling us of your background and your qualific  
18 tions and the field of medical practice in which you  
19 are presently engaged.

20 DR. SWANSON: I am a graduate of Edin-  
21 burgh University, in 1942. After the War, during par  
22 of which I was a rehabilitation officer of the R.A.F.,  
23 I wrote my specialist examinations, which are called  
24 in Scotland Membership of the Royal College of  
25 Physicians, and subsequently was made a Fellow of that  
26 College. I also wrote my thesis for an M.D. Degree  
27 which is a little different from the way we do it in  
28 Canada. Then, for six years, I did research in what  
29 is called the Chronic Rheumatic Disease field, two  
30 years in Britain, two years at Harvard Medical





1 and two years on coming to Canada at the Toronto  
2 hospitals, chiefly at Sunnybrook Veteran Hospital, and  
3 I wrote the examinations, firstly, to licence me to  
4 practice, and also for certification as an internal  
5 medicine specialist. Since 1963, I have been practising  
6 as a consultant and specialist in chronic rheumatic  
7 diseases.

8 I am on the staff, as a Director, of the  
9 Arthritis and Arthritic Hospital and on the staff of  
10 the Toronto general hospitals, and until two weeks  
11 I was on the staff of Sunnybrook Hospital.

12 I was Medical Director of the Canadian  
13 Arthritis Society of Ontario from 1960 to 1964, and I  
14 was President of the Canadian Association of  
15 Therapists from 1960 to 1966.

16 MR. GUTHRIE: Doctor, thank  
17 we are concerned with here is a suggestion, part  
18 contained in the brief of the Mine, Mill & Smelter  
19 Workers Union, with which I think you may have some  
20 familiarity, that the conditions described in that brief  
21 as rheumatism and arthritis should be considered  
22 inclusion in the Schedule of Diseases, Schedule 3,  
23 to the Workmen's Compensation Act. We wondered this  
24 morning if you could tell us something of the  
25 of those diseases, if that is a proper term,  
26 in the population and, more particularly, in your  
27 perience, something of the incidence that you find  
28 the mining industry, let's say, or in any other indu  
29 or work where they may be noted and  
30 experience whether these differences





1 of a substantial nature and matters of that kind. I  
2 think I would like you to start in in your own way, if  
3 I have given you a specific indication of what we want  
4 to hear.

5 DR. SWANSON: I might say at the onset  
6 that I haven't seen the brief, and perhaps I should  
7 state that and then give my views on the subject.

8 MR. GUTHRIE: Well, it is a very short  
9 passage, Doctor, and perhaps if I simply read it now.  
10 It is at page 14 of the Mine, Mill brief. It is headed,  
11 "Rheumatism and Arthritis."

12 "We strongly urge the inclusion of these  
13 conditions in the schedule of Industrial  
14 Diseases. We submit that workers gener-  
15 ally, in the industries covered by our  
16 jurisdiction and in particular in under-  
17 ground operations are subject to contin-  
18 uous repetitive stress, exposed daily to  
19 wetness, cold and draughts, and wide vari-  
20 ants in temperature, conditions that are  
21 generally recognized as precipitating  
22 causes of these two conditions."

23 Now, Mr. Kennedy for that Union is  
24 going to deal in more detail with that, of course, but  
25 we wanted to let you have an opportunity to get away  
26 this morning.

27 DR. SWANSON: I thought, first of all,  
28 we should define what we mean by rheumatism and arthritis,  
29 because these terms are very confusing to the lay public.

30 First of all, there is no such thing as







1 rheumatism, it doesn't exist as an entity, but it is a  
2 very convenient/<sup>word</sup>that is commonly used by most of us to  
3 refer to pains of unknown origin that arise in bones  
4 or joints, and soft tissues that surround them such as  
5 muscles, tendons, ligaments. Everybody in their lives  
6 will complain of this word rheumatism; they will say  
7 it aches or something like that, but there is no disease  
8 like smallpox; it doesn't exist as a diagnosable entity.  
9 The word "Arthritis" is a more satisfactory word to use  
10 when dealing with some inflammation of the joints, but  
11 equally it is misused if it isn't defined correctly and  
12 qualified. By definition, it means inflammation in a  
13 joint, and there are two kinds of joints one should  
14 discuss. One is the joint that has fluid in it, like  
15 a finger or a knee, and we call that a synovial joint.  
16 Its chief function is to allow for movement as well as  
17 stability. There is a second kind of joint which  
18 doesn't have fluid in it in the same way, but which has  
19 fibrous tissue, such as you have between the bones of  
20 the back and the pelvis, and we refer to these as discs,  
21 because they look like discs, and their chief function  
22 is to maintain stability rather than movement. The  
23 synovial joint allows for movement rather than stability;  
24 the disc allows for stability and less movement.

25 As I say, you have to qualify the word  
26 "Arthritis" with another word to show whether it is  
27 traumatic, it is an injury kind of arthritis, because  
28 there are, as far as we know, at least 155 different  
29 kinds. So, just to say I suffer from arthritis is  
30 meaningless. If I could briefly explain some of the





1 kinds which will come into this discussion: First of  
2 all, if you are injured and suffer sprains, that would  
3 be traumatic arthritis, and perhaps we wouldn't call it  
4 arthritis, we would call it synovitis, which is inflamm-  
5 ation of the synovial. We call it a traumatic synovitis.  
6 If it got infected by dirt or injury occurring, as a  
7 person suffering from a sore throat, this we would call  
8 infectious arthritis, and it may be tubercular arthritis.  
9 But it is the word that qualifies arthritis which tells  
10 you the kind of arthritis. On the other hand, it might  
11 not be a bacteria that gets into it; it might be a  
12 chemical, a substance such as uric acid, but it gets  
13 into the joint and irritates it, and we call that  
14 gouty arthritis, and it is not an uncommon disease; it  
15 is on the increase. But it is a disease of disordered  
16 uric acid metabolism. There is calcium. There is  
17 another very real one, but they do exist as separate  
18 entities, and the word "Arthritis" has to be qualified  
19 to make some meaning. If you get repeated minor sprains  
20 of a joint - this may occur to all of us throughout our  
21 lives - we call this osteo-arthritis, and it is by far  
22 the commonest. It is not really an inflammation; we  
23 like to call it osteo-arthrosis, because it is coming  
24 more into use, and if you ask if there is a difference  
25 between osteo-arthritis and osteo-arthrosis, the  
26 answer is no. It is pertinent to go into this a little  
27 bit because there are two kinds. One is what we call  
28 a secondary arthrosis, which would happen after an  
29 injury. For instance, if a hockey player tears a  
30 cartilage, that cartilage will develop arthrosis quicker





1 than one which isn't damaged. There is a primary  
2 arthrosis which we call generalized osteo-arthritis,  
3 and this is characterized by having bumps at the ends  
4 of the fingers, and a great many people have these,  
5 particularly women. It occurs as spurs and osteophytes,  
6 and they occur in the back, the head, the hips, the big  
7 toe and the thumb. In other words, the joints which  
8 take the biggest strain seem to develop this osteo  
9 arthrosis. <sup>question</sup> The/of occupation, climate, race, stress  
10 comes into this very greatly, and I will come back to  
11 that.

12 Just to complete the picture, another  
13 very common arthritis is the one which we call rheumatoid  
14 arthritis, and you will notice the word "Rheumatism"  
15 creeping into it. We don't know the reason for this.  
16 This is probably a disease which is a disorder of  
17 immunity. That is, something damages the joint,  
18 possibly a bacteria, possible a chemical, possibly a  
19 direct blow, and in some way the body doesn't deal  
20 with it in its usual repair fashion and the struggle  
21 goes on a little longer and the body makes a antibody  
22 of this mess and the antibody is produced to that  
23 person so that the condition goes on and on and on.

24  
25  
26  
27  
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1 I am sorry to go into this in such detail,  
2 but it is important to make it clear that rheumatoid  
3 arthritis is a serious disease with immuno-logical causes  
4 probably and is quite distinct from oesteo arthritis  
5 which seems to be wear and tear steadily throughout one's  
6 life.

7 Now, there are, as I say, many other  
8 kinds of arthritis, but I think for the purpose of this  
9 discussion that is probably sufficient.

10 I think it would be pertinent to, at  
11 this point, deal with the question of injury related  
12 to the onset of rheumatoid arthritis. Rheumatoid  
13 arthritis exists probably in about three to four percent  
14 of any given community. This has been very thoroughly  
15 studied in various parts of the world which I will be  
16 quoting from. The lowest is about 2 percent and after  
17 the age of 75, 6 percent incidence, so we can say  
18 probably 4 percent of any one community are likely to  
19 have rheumatoid arthritis to a lesser or greater extent.  
20 It is quite often there, but not recognized because the  
21 condition is so mild.

22 We do not believe that any direct injury  
23 can cause rheumatoid arthritis, but we do believe it is  
24 reasonable that if somebody has rheumatoid arthritis,  
25 maybe not recognized, but has it, then injury may trigger  
26 off an attack.

27 A simile I would like to use for that  
28 is that if you have a cannon with a shell in it  
29 then that threat is within it. We don't know how the  
30 shell gets in but maybe in all that patient's life it  
may never be fired but if the appropriate trigger is





1 pulled it fires off and you get an attack. Triggers  
2 include stresses of a physical nature or an emotional  
3 nature, that is to say, direct injury may be the trigger  
4 that fires off that shell if the shell is in the gun.  
5 Many people don't have that shell in their gun, but if  
6 they do then there is a reasonable chance that they  
7 may fire it off.

8 The same is probably true of gouty  
9 arthritis and we can demonstrate this experimentally.  
10 You can stress a person by giving them a lot of  
11 Cortisone which produces a stress, suddenly stopping  
12 it and you get an attack. By analogy, we think this  
13 may happen to Rheumatoid arthritis and one or two others.

14 In other words, to sum up, we don't  
15 think that any one injury can cause that disease but it  
16 may aggravate it considerably and then, of course, the  
17 question is how long can that aggravation go on, when  
18 does the effect of that initial blow wear off - six  
19 weeks, six months or two years? This is a very hard  
20 question to answer.

21 I was specifically asked what was the  
22 effect of mining particularly on arthritis, and it so  
23 happens there are a great number of studies that have  
24 been done on this. I have very briefly participated in  
25 part of it. It started in England when I was doing  
26 some of my post-graduate training and research under  
27 Dr. Keldron. Dr. Keldron is the first professor of  
28 rheumatology in the British Commonwealth and he  
29 initiated a study on coal miners in England with one  
30 of his assistants called Dr. John Lawrence. Dr. Lawrence





1 is now a world authority on the epidemiology of arthritis.  
2 There are a great many articles that have been written  
3 in his name, some of which I have brought along today.

4 I would like to read you some extracts  
5 from their works and then, after that, say something about  
6 climate, atmosphere, in relation to arthritis.

7 THE COMMISSIONER: These papers refer  
8 to particular areas or situations in particular mines?

9 DR. SWANSON: Yes, I have the names of  
10 the mines if you wish them.

11 THE COMMISSIONER: All I had in mind was,  
12 would there be any difference in the traumatic conditions  
13 in those mines from those in Northern Ontario?

14 DR. SWANSON: There may be, these are all  
15 done in coal mines. I believe the Northern Ontario ones  
16 are largely hard rock mines, so there is some difference  
17 on that point and the height of the seam is important  
18 too. They went into this and they compared wet and  
19 dry coal mines and they selected a height of 4 feet 6  
20 to 5 feet 6 because it so happened that both mines had  
21 comparable seams. One of the mines had less than that,  
22 3 feet high, and that introduced another element of  
23 stooping. So this was discarded in the final control.  
24 They compared back injuries to the discs in coal miners,  
25 dock workers, manual workers and office workers, so  
26 they had a complete contrast in occupation and this has  
27 been done in Manchester at Leigh Colliery, at Bedford  
28 Colliery and Firbank Colliery.

29 Then, they went down to South Wales and  
30 compared an urban community which took in the Rhondda







1 Valley and a rural community close by to compare the  
2 incidence of back pain and disc degeneration of farmers  
3 and farmer's wives, as opposed to miners and miner's  
4 wives. They also compared similar population studies  
5 for miners, particularly in Holland and Finland, in the  
6 Lowlands of Scotland and Wensleydale, which is a rural  
7 district of England. Subsequently, but not pertinent  
8 to this discussion, similar studies have been done in  
9 various parts of the United States amongst the Indian  
10 population and amongst some of the Indian population in  
11 the Queen Charlotte Islands in Canada. It is a wide-  
12 spread study and some of it was summed up by Dr. Lawrence,  
13 a Dutch Doctor de Graaff and I think a Finn called Laine  
14 in a large volume that was published in 1963 called  
15 The Epidemiology of Chronic Rheumatism. Note again,  
16 the word that doesn't mean anything but does convey  
17 what we want it to convey.

18 I would like to read this part entitled  
19 Positive Factors in Disc Degeneration. Now, the disc,  
20 as you get older, becomes drier, slightly narrower  
21 and therefore more vulnerable. It is more likely to be  
22 squashed or torn and this is what they say:

23 "One of the most studied features in  
24 the epidemiology of chronic rheumatism  
25 is its relation to disc degeneration.  
26 In a survey of rheumatism in miners and  
27 other occupational groups, severeradiolog-  
28 ical changes of disc degeneration  
29 in the lumbar spine were found in 43 per-  
30 cent of miners, but in only 7 percent of





1 office workers. Conversely, only 8 per-  
2 cent of miners had radiologically normal  
3 spines, compared with 67 percent of  
4 office workers. The findings in the  
5 manual workers - - engineers, painters,  
6 bricklayers were intermediate but nearer  
7 to the office workers than the miners.  
8 A group of dock workers studied later  
9 showed changes intermediate between those  
10 of the miners and the light manual workers."  
11 Then they went into some details.

12 THE COMMISSIONER: Before you go on, you  
13 took part in some of these, did you?

14 DR. SWANSON: More as a spectator. I  
15 saw it start.

16 THE COMMISSIONER: I was curious about  
17 them. These are coal mines?

18 DR. SWANSON: Yes.

19 THE COMMISSIONER: And in these coal  
20 mines in Britain, it was largely a matter of pick work  
21 and shovel work, was it not, on the part of the miners?

22 DR. SWANSON: Yes.

23 THE COMMISSIONER: So that is the type  
24 of occupation you are considering?

25 DR. SWANSON: Yes.

26 THE COMMISSIONER: There was not the  
27 mechanization that there is today?

28 DR. SWANSON: In 1950 and 1951, I don't  
29 think there was any mechanization in those mines.

30 This study that he was quoting from





1 was made on men between the ages of 40 and 50, so the  
2 effective age as a natural cause of this can be excluded.  
3 They say.

4 "Trauma, exposure to wet and work in  
5 a stooping position aggravated the symptoms  
6 and disability but had no effect on the  
7 X-ray appearance and the lower dorsal  
8 spine showed the same occupational in-  
9 cidences as the lumbar spine."

10 In some detail - and I would recommend  
11 anybody who was interested in this to peruse this partic-  
12 ular article --

13 THE COMMISSIONER: I suppose, Doctor,  
14 what are the situations in those coal mines in England?  
15 Do they work in narrow places where they have to stoop  
16 a lot?

17 DR. SWANSON: They tried to exclude that  
18 and I believe from one of the sentences that he mentions  
19 here, they compared the miners of one colliery with  
20 another who worked in the seam between 4 feet 6 and  
21 5 feet 6, but I am sure this is not true of the whole  
22 study. The overall incidence takes into effect all  
23 the miners in these two collieries, whatever position  
24 they worked in. But he goes into this in more detail  
25 than I think we can discuss this morning, in an article  
26 of the British Journal of Industrial Medicine, Volume  
27 12, 1955, page 249, where he discusses posture, work  
28 in wet conditions, heavy lifting, prolonged lifting,  
29 damp, air velocity and also the relationship to the  
30 knee, as opposed to the back. Let me deal with that.







1 He says: "Apart from injury to the knee  
2 we have found no factor in mining which appears causally  
3 related to osteo arthritis of the knee." But they did  
4 find that osteo arthritis of the knee was common  
5 amongst the miners who pushed heavy trucks and that it  
6 was related to injury.

7 They also found --

8 THE COMMISSIONER: Will you read that  
9 statement again, please?

10 DR. SWANSON: "Apart from injury to the  
11 knee we have found no factor in mining which appears  
12 causally related to osteo arthritis, but a history of  
13 injury was obtained in 4 percent of miners, greatest  
14 amongst roadway workers", so the corollary is that  
15 the roadway workers injured the knees and got more osteo  
16 arthritis.

17 MR. GUTHRIE: You are just speaking of  
18 the knee here?

19 DR. SWANSON: Just the knee at this  
20 moment. They also state that osteo arthritis - that is  
21 the wearing out of a joint - was commoner at elbow,  
22 wrist and hand in miners than any of the other occupa-  
23 tions they studied.

24 MR. GUTHRIE: Did they say, Doctor,  
25 by how much?

26 DR. SWANSON: I don't think so.

27 Perhaps I should say at this point that  
28 when you get this disc degeneration in the back, the  
29 symptoms are pain in the back as a rule, more frequently  
30 pain going down the back of the legs which we refer to





1 usually as either a referred pain or sometimes what we  
2 call sciatica. They call that the back-hip sciatic  
3 pain group.

4 THE COMMISSIONER: You are talking about  
5 disc degeneration?

6 DR. SWANSON: Yes.

7 THE COMMISSIONER: That is where you will  
8 have a narrowing of the space between the vertebrae?

9 DR. SWANSON: Right.

10 THE COMMISSIONER: But when you talk  
11 about disc degeneration, is that different from an ex-  
12 truded disc?

13 DR. SWANSON: Yes.

14 THE COMMISSIONER: This is just where  
15 they get smaller and narrower?

16 DR. SWANSON: Yes. Dr. Ian MacNabb has  
17 rather dramatically described the difference between  
18 these two as saying when it is pushed out it is like a  
19 blowout in a tire, when it goes down degeneratively it  
20 is like a slow flat, which I think explains it rather  
21 well.

22 THE COMMISSIONER: This is the degenerative  
23 condition you are talking about?

24 DR. SWANSON: Yes. If you have an injury  
25 to the back and get an extruded disc, then that segment  
26 is weak and osteoarthritic changes will take place in  
27 that area, but that is not disc degeneration. That  
28 will show up as little spurs on the side of the disc  
29 where, presumably, the body is trying to seal it off  
30 with a new bridge of bone and that is not disc degenera-





tion, that is extruded disc with secondary attempted repair.

Briefly, I thought you might like to know what we feel about climate. It has long been an old wife's tale that on a damp day or just before a thunderstorm, people with "arthritis" and by that, we usually mean osteo arthritis, may feel worse. Some investigations and experiments have been done to try to sum this up on a controlled situation. This was originally done by a Swede, Dr. Edstrom, but more recently in very great detail in Philadelphia by Dr. Hollander. Let me describe what he did: He designed an air-conditioned pressurized completely ionized room which had no windows and represented a ward with two beds. To get into this room, you had to go through a pressure lock - I have been in this room, I have seen it - so that there was no chance of losing the pressure that was in the room. And then by various means they made the room hot, cold, wet or dry, put the barometric pressure up or down and they could ionize the air by putting certain chemicals in it. Then, the practice was for two people to be in this room for sometimes six weeks during which time the weather was altered and the patients did not know what was happening, nor did the doctor nor the nurse who were attending the patients on the days they were in there. So now they knew what the weather was.

In the chamber they did various tests, blood conditions, at least twice a day they measured the strength of blood, the time it took for a patient







1 to get up from his chair, walk across the chamber, re-  
2 seat himself, blood pressure, pulse and the number of  
3 joints that were sore, how the patient felt, and the  
4 doctor made his own assessment, so by various means  
5 they had a pretty good idea whether that patient was  
6 getting better or worse.

7 They concluded, after they had done a  
8 great number of people, that the only condition under  
9 which these people felt worse was when the humidity was  
10 getting greater and the barometric pressure was going  
11 down, which are the conditions just before a storm as  
12 a rule. I will read what they said:

13 "It would appear that at least one com-  
14 bination of changing factors, rising  
15 humidity, falling barometric pressure  
16 fairly consistently exerts a detrimental  
17 effect on arthritic symptoms and signs.  
18 It would also appear that the changing  
19 conditions rather than the high humidity  
20 or the barometric pressure are responsible.  
21 It now seems reasonable to conclude that  
22 the weather effect on arthritis is a  
23 definite phenomenon and not just another  
24 old wife's tale but it is not implied that  
25 climatic changes have any direct bearing  
26 on the cause of arthritis, nor is it  
27 believed that a constant climate would  
28 have any fundamental curative affect."

29 In other words, it is real, they feel  
30 worse, but it does not necessarily mean that they are





1 worse and, personally, I think we all feel a little  
2 bit tired and unhappy on a slightly damp day when there  
3 is a storm coming and it gets irritating to a lot of  
4 conditions, not just arthritis, but it aggravates the  
5 pre-existing symptoms.

6 MR. GUTHRIE: What about wetness as such,  
7 apart from the change you speak of, say a cold damp.

8 DR. SWANSON: I think if you are exposed  
9 to prolonged cold damp it is detrimental too. I  
10 don't think that will give you arthritis but, conceivably  
11 it can lower your body's resistance and if you catch  
12 some infection that may be the thing that triggers off  
13 an attack if you have the disease in you and I am talking  
14 of rheumatoid arthritis or rheumatic fever. Rheumatic  
15 fever we did not mention. That is one of the diseases  
16 that attacks the heart more now than joints but it used  
17 to attack the joints a great deal. For some reason,  
18 its nature has changed in the last sixty years and it  
19 is a much more serious heart disease which can be  
20 described as licking the joints and biting the heart.  
21 We do know this comes from a streptococcal throat  
22 which may be induced by catching cold.

23 MR. GUTHRIE: Could you go on to express  
24 an opinion as to the effect of wetness or dampness on  
25 the degenerative form, the osteo arthritis?

26 DR. SWANSON: Yes, I would again quote  
27 Dr. Lawrence that those working in wet conditions had  
28 more back-hip sciatic pain and more evidence of this in  
29 their back, but less severe radiological change, what-  
30 ever that means.





1 THE COMMISSIONER: Less severewhat?

2 DR. SWANSON: Radiological change; in  
3 other words, they had more symptoms but not necessarily  
4 any more evidence of disease.

5 There was one question you asked me, sir,  
6 before about posture. Another statement he makes is  
7 "In miners the relationship between position at work  
8 is great between the position and the spinal symptoms  
9 and the incapacity. The more stooped, the more affected,  
10 but not necessarily the more X-ray change." In other  
11 words, they felt worse, it was more difficult, but it  
12 did not mean that the spine was any worse as far as  
13 X-ray evidence was concerned.

14 I may say they tried to eliminate  
15 emotional factors by various psychometric tests. They  
16 also eliminated the length of the spine and so on and  
17 they came to the conclusion that the miners they had  
18 examined were a fairly stable group. I suppose the  
19 emotionally unstable found it impossible to work down  
20 in the mine and had gone. That is just my own opinion.

21 THE COMMISSIONER: Well, let us summarize  
22 what you have said for our purpose. I am chiefly in-  
23 terested here in one problem and that is, is the  
24 incidence of whatever you might call it - rheumatism  
25 or arthritis, noticeably greater among miners, than  
26 it is among the general public and, again, when I get  
27 into that, of course you refer to these particular  
28 papers in England, but I would ask you to say whether  
29 you base your opinion on those papers or not because  
30 it seems to me that the situation in the mines has







1 changed substantially since the days when practically  
2 all of the work was done by pick and shovel. It is a  
3 very involved question, Doctor.

4 DR. SWANSON: Very. I have puzzled over  
5 this since you asked me to appear before this Commission.  
6 I am well aware, and I have made this clear, that these  
7 are figures, the only figures that we have that are  
8 reliably done. This is a very good group of research  
9 workers, but they do refer to coal miners in Europe.  
10 There is a study which I have not quoted from that was  
11 done in Pennsylvania miners and quoted by Dr. Caplan  
12 and it comes to the same conclusions very largely. I  
13 don't know whether this is a recognized work or not, but  
14 this is 1966, just hot off the press.

15 THE COMMISSIONER: You are referring to  
16 a recent study?

17 DR. SWANSON: A recent study done in  
18 New Kensington, Philadelphia.

19 MR. GUTHRIE: Is that on coal miners?

20 MR. SWANSON: Yes. They studied 178  
21 coal miners over the age of 40 representing one local  
22 union in the area of Russelton, Pennsylvania and this  
23 is what their conclusions were:

24 "That there are degenerative changes of the  
25 lumbar intervertebral discs as measured  
26 by observable radiographic narrowing  
27 an  
28 is not accounting for aging in itself."

29 This we would accept. "There is a direct  
30 relationship between aging and the spurring," that is  
the repairing process that goes on. It appears that the





1 duration of heavy work by coal miners has no bearing  
2 upon the development of disc changes, but there is an  
3 association between the body spurring and the duration  
4 of the heavy work." In other words, the heavier the  
5 work the more damage is done to the tissues around the  
6 disc, rather than the disc itself. That is a conclusion  
7 I am not sure about.

8 THE COMMISSIONER: And he started out by  
9 saying what - little evidence of degenerative change  
10 with the body spurring?

11 DR. SWANSON: "But there is an association  
12 between body spurring and the duration of the heavy  
13 work", the longer the heavy work the more spurring/there  
14 is but not necessarily degenerative discs.

15 THE COMMISSIONER: Not the degenerative  
16 disc but the degenerative vertebrae, is that it, - -  
17 maybe not degenerative but arthritic growth causing  
18 arthritis.

19 DR. SWANSON: There is evidence of the  
20 ligaments around the disc being stretched and, there-  
21 fore, the body retaliates by calcifying but it doesn't  
22 mean that the disc has become narrower; in other words,  
23 if you look at the X-ray that they are discussing, the  
24 disc is not narrow but it does have spurs around it  
25 suggesting that area has been under constant strain.

26 THE COMMISSIONER: The spurring would  
27 cause some arthritic or some rheumatic pains?

28 DR. SWANSON: Yes, I think it is associa-  
29 ted with it but the problem here is, once you have  
30 developed a spur it stays there for life. It may get





1 a little larger but you can't look at it and say, "That  
2 one is painful".

3 THE COMMISSIONER: Isn't spurring fairly  
4 general in all people beyond a certain age?

5 DR. SWANSON: Probably, because they may  
6 have had some mild injury in their back.

7 THE COMMISSIONER: Maybe I am not talking  
8 about the same thing. Is there some vertebrae degenera-  
9 tion apart from intervertebral disc degeneration in  
10 people above a certain age, say, 50?

11 DR. SWANSON: Vertebrae in women become  
12 osteo-porotic or porous, because the protein in the  
13 vertebrae is removed after the menopause, to a lesser  
14 extent in men, so the calcium has nowhere to stick  
15 so it comes out and that is a serious condition in  
16 women. That is not really the same thing. It has no  
17 relationship at all with degenerative discs or spurring.

18 THE COMMISSIONER: I may be thinking of  
19 something entirely different, but it runs in my mind I  
20 have heard the statement that everybody over 50 years  
21 of age has a certain amount of arthritic development in  
22 the spine or change in the spine that is a degener-  
23 ative change.

24 DR. SWANSON; I think this is probably  
25 true but in a very loose way that we do get in the  
26 habit of saying, well, we all do get some wear and tear.  
27 You can't live to 50 without having had some wear and  
28 tear in your back which we describe as spurring. They  
29 make the definite statement which is, I say, a little  
30 surprising to me that "Degenerative changes are not an







1 accompaniment of aging in itself." I suppose what they  
2 mean is neither is hardening of the arteries a disease,  
3 but it is synonomous with old age. And the older you  
4 live the more chance you have of getting it, the older  
5 you live the more chance you have of getting some kind  
6 of damage that will irritate the disc or produce liga-  
7 mentous strain that we eventually see classified as  
8 spurring, but it doesn't mean you have to be old to get  
9 it: You can get it when you are young, so it is a very  
10 loose thing to say that old age is necessarily the same  
11 thing as having wear and tear changes in the spine. The  
12 oldest patient I have ever seen was a Russian lady whom  
13 I saw last year, 101, and she had no evidence of disc  
14 degeneration in her body.

15 THE COMMISSIONER: That is why she lived  
16 to be 101?

17 DR. SWANSON: It could well be. This  
18 is a very confusing subject and I am sorry if I have not  
19 made myself clear.

20 THE COMMISSIONER: We were aware of the  
21 difficulties when we headed into them. I think you have  
22 made it a little clearer, although I am not sure of the  
23 conclusions.

24 MR. GUTHRIE: Are there other conclusions,  
25 or have you given them?

26 DR. SWANSON: That is the gist of it.

27 THE COMMISSIONER: Really, all you have  
28 given us is what has been stated in England?

29 DR. SWANSON: That is because they are  
30 the only people that I know of who have studied this in





1 an epidemiological way. I think the only way to get  
2 at the truth of it and the situation in our northern  
3 miners would be to set up a similar study and take so  
4 many miners and so many manual workers and so many  
5 office workers. I would think that the conclusions I  
6 have given you are largely what you would find in the  
7 northern miners too, if they were under the circumstances  
8 of bending, working in draughts, having damp conditions.  
9 If, on the other hand, they were in warm, relatively dry  
10 upright positions, presumably they would not have the  
11 same amount of back trouble.

12 THE COMMISSIONER: You, with your wide  
13 experience in this country with arthritic conditions  
14 have not had any reason to make any particular observa-  
15 tions on your own about people you have seen? I suppose  
16 you see a relatively limited number of people in the  
17 mining industry?

18 DR. SWANSON: The ones whom I see are  
19 those who have had accidents and that is a different  
20 thing. If you have an accident, then that brings on a  
21 secondary change and a secondary type of osteo arthritis.  
22 What we have been talking about is the primary kind  
23 which seems to come on because of the occupation that  
24 is hazardous to a back or a knee. The knee, I think,  
25 would be exactly the same no matter whether you were  
26 on the surface or down the mine. If you injured your  
27 knee pushing something heavy on a dock or down below,  
28 then you are going to get a secondary kind of osteo  
29 arthritis. I don't see any trouble about accepting that  
30 conclusion. It is a fact that somebody is working in





1 unpleasant conditions, tough conditions, does that  
2 prejudice the safety of the back and I would have to  
3 say that if they are in conditions of stooping, twisting,  
4 then they are more likely to injure their back than  
5 not. It need not be a traumatic injury, it may be a  
6 steady one, plus one, plus one, day by day, adding up  
7 to a hundred.

8 MR. GUTHRIE: You have just said stooping,  
9 twisting and earlier you said bending. These are all  
10 matters of posture and lifting was another, I think.

11 DR. SWANSON: Lifting in the position  
12 of a slight variance from the best posture. If you  
13 lift something in an awkward position, you put a  
14 shearing strain which must surely work out.

15 MR. GUTHRIE: I have tried to get at the  
16 things which may be different with miners from the rest  
17 of us and distinguish them as an occupational group so  
18 that those are matters of posture, another you mentioned  
19 was wetness and, if I understood you, the effect, as  
20 you understand it of wetness, is more a matter of pain  
21 than of observable change.

22 DR. SWANSON: That is the conclusion they  
23 adopted. They came to it and I have to agree with it.

24 MR. GUTHRIE: The other factor you  
25 mentioned was air velocity, by which you mean draughts,  
26 I take it?

27 DR. SWANSON: Yes.

28 MR. GUTHRIE: Have I mentioned all the  
29 things that might be said to distinguish miners as  
30 an occupational group?







1 DR. SWANSON: Will you go over them  
2 again?

3 MR. GUTHRIE: Posture, bending, stooping,  
4 twisting and lifting.

5 DR. SWANSON: And combinations thereof -  
6 lifting in a bent position.

7 MR. GUTHRIE: Wetness?

8 DR. SWANSON: Wetness will aggravate it  
9 whether it is in Timbucktoo or the North of Scotland.

10 MR. GUTHRIE: And air velocity, draughts?

11 DR. SWANSON: Yes.

12 MR. GUTHRIE: Is there anything else?

13 DR. SWANSON: Draughts least, that was  
14 the conclusion that Dr. Lawrence came to. Air velocity  
15 has little to do with it, but its presence must be one  
16 factor.

17 MR. GUTHRIE: You did mention injury,  
18 of course, but there is nothing special about injury  
19 to a miner?

20 DR. SWANSON: It could happen anywhere.

21 MR. GUTHRIE: Now, if I might read to  
22 you, Doctor, the definition of industrial disease in  
23 the Workmen's Compensation Act found in Section 1, Sub-  
24 section (1) Clause (I and it means:

25 "Any of the diseases mentioned in  
26 Schedule 3 and any other disease peculiar  
27 to or characteristic of a particular  
28 industrial process, trade or occupation."

29 Now, what we are trying to get at, of  
30 course is:is this disease one that could be said to be





1 "characteristic of or peculiar to" mining which is  
2 really the thing we are looking at? Could you go that  
3 far?

4 DR. SWANSON: I think it is an occupational  
5 hazard to a back if the mining entails lifting in a  
6 stooped position.

7 MR. GUTHRIE: That you could say of  
8 a dock worker, could you not, or a stevedore?

9 DR. SWANSON: Yes, but if Lawrence's  
10 work is to be accepted - and he is accepted all over the  
11 world as one of the authorities - his figures were  
12 dramatic. The very first figure I quoted to you was  
13 43 percent of the X-rays of miners were abnormal and  
14 yet only 7 percent in office workers. I have not got  
15 the figures here of the dock workers, but he said it  
16 was intermediate between the miners and the manual  
17 workers, so that his conclusion is there is something  
18 different about the occupational hazards in a coal mine  
19 from those of a dock, presuming the dockers are exposed  
20 to cold and wet and gales and unpleasant conditions  
21 too.

22 MR. GUTHRIE: You haven't the precise  
23 figure on the dock workers?

24 DR. SWANSON: I haven't it here. It is  
25 possibly in this one here. I didn't actually look it  
26 up but it is somewhere here, I think. This is the article  
27 they refer to. No, they give the manual workers and  
28 the office workers, but not the dock workers. I would  
29 have to look for it for you. I am sure I could get it.

30 MR. GUTHRIE: There are no figures there





1 for work in the forest?

2 DR. SWANSON: No.

3 MR. GUTHRIE: And what was included in  
4 manual labourers, was that indicated?

5 DR. SWANSON: Light manual work, engineers,  
6 painters or bricklayers.

7 MR. GUTHRIE: I have nothing else, thank  
8 you.

9 THE COMMISSIONER: We have not made a  
10 practice of this or done it before, but perhaps before  
11 Dr. Swanson leaves if anyone here has any particular  
12 questions they would like to ask in relation to the  
13 matter which he has been dealing with, I think we might  
14 allow that to be done.

15 DR. POWELL: I would like to ask Dr.  
16 Swanson in view of his excellent presentation, partic-  
17 ularly of the miners in Britain, we wondered if, as  
18 a result of this excellent work that has been quoted,  
19 did the British Government do anything to include in  
20 compensation any question of backs or this particular  
21 type of arthritis within their compensation or their  
22 Industrial Injuries Act?

23 DR. SWANSON: I don't know, I am sorry  
24 to say, Dr. Powell. I am sure the British have a very  
25 comprehensive health scheme, so that a miner is going  
26 to be looked after anyhow, but the question of compensa-  
27 tion I don't know about.

28 THE COMMISSIONER: Under the present  
29 British scheme, it would not really enter it very much,  
30 I suppose for it is automatic compensation whether it







1 is for industrial injury or whether it is for some other  
2 health matter, but this is fairly recent up until now  
3 and we might look into that and we will.

4 DR. SWANSON: I would like to suggest  
5 that this is so important that it should be the subject  
6 of a study.

7 THE COMMISSIONER: I had that in mind  
8 too. It seemed to me that it is asking quite a lot of  
9 this Commission to make up its mind, these figures are  
10 1951 and relate to situations which might readily be  
11 quite different from the situation as it exists today  
12 in our mines, but certainly the figures are striking  
13 enough there to call for some careful research. Would  
14 that be a big proposition to carry on a similar research  
15 project to the one that was conducted in Britain in  
16 1951?

17 DR. SWANSON: It is a laborious process.  
18 What Dr. Lawrence does is, he and a social worker  
19 usually interview all the miners. All the miners have  
20 an X-ray taken of certain key parts of the body which  
21 they were studying, the knee, back, the neck and the  
22 hands, and then the X-rays were read by several people  
23 independently and if they agreed on certain findings  
24 these were passed: Where they didn't agree they would  
25 meet together and discuss it. It was done exceedingly  
26 fairly. Blood tests were taken for certain diseases,  
27 including the rheumatoid factor of the rheumatoid  
28 disease and all information from whatever part of the  
29 world it was done was sent back to Manchester, so it  
30 was the same laboratory and same man who pronounced the





1 collective opinion or judgment.

2 I have met several people engaged in  
3 these studies getting together to discuss the X-rays,  
4 as far away as B.C., where they were doing a study on the  
5 Haida Indians and on the Pima Indians in Washington state,  
6 with Dr. Lawrence who agree or disagree with the X-ray  
7 findings and they stay at it until they agree, so it is  
8 a very lengthy bit of work. Some of it would require  
9 a year, it would require somebody of the calibre of  
10 Dr. Lawrence or somebody who would be acceptable to  
11 the Commission of that standard and an assistant who  
12 might be another doctor or a social worker to help  
13 with the interviewing.

14 THE COMMISSIONER: Thank you.  
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1 MR. HALL: May I ask a question of Dr.  
2 Swanson?

3 Dr. Swanson, what, in your opinion,  
4 would be the effect of a workman who was exposed to  
5 wide variance in temperature daily? I am thinking now  
6 of a man who is commonly called a nipper, moving from  
7 one level to another, doing it constantly during the  
8 day and there are sharp variations in temperatures from  
9 one level to another?

10 DR. SWANSON: I suppose that is what is  
11 called a stress and, therefore, the bit of body he may  
12 be using under those circumstances would be stressed  
13 more than at another time when he wasn't under these  
14 circumstances; and if he produces symptoms of disc  
15 degeneration, then that would tend to wear out his back.

16 THE COMMISSIONER: I thought Mr. Hall  
17 was referring to a traumatic change or temperature  
18 change. I understood you to say that there is strong  
19 evidence that it had much effect.

20 DR. SWANSON: It was said that this  
21 was never a causative factor under the conditions of  
22 Dr. Keldron's experiment. If you were working under  
23 these circumstances, your body presumably would wear  
24 out quicker than if you were sitting at a desk. One is  
25 a stress situation and the other is not. In these  
26 surveys, it deals with a group of people who are not  
27 all the same. We have Billy Watson, who is a tough guy  
28 and who injures his discs, but he doesn't complain about  
29 it. On the other hand, you have an intellectual person  
30 who is horrified at walking 100 yards. So you cannot







1 apply a statistical study to any one man beyond saying  
2 there is a trend that it is likely something must happen.  
3 After all, there are miners who have been underground all  
4 their lives and who have never complained about backache  
5 at all, and there are those who complain about it as  
6 soon as they go down. You have to allow for variation,  
7 which is very great.

8 THE COMMISSIONER: There is one other  
9 question which occurs to me. I don't know whether it  
10 will have an effect on this consideration or not.

11 Is there an increase in the general  
12 incidence of arthritic and rheumatic troubles, or gout?

13 DR. SWANSON: That is a very hard question  
14 to answer. I think there are more doctors aware of  
15 the diagnosis conditions, and there is more can be done  
16 about it today. So they will come to a doctor quicker  
17 and earlier than they used to. The Arthritis Society  
18 has made the people aware that something can be done.

19 As far as gout is concerned, I think it  
20 is on the increase. It has to do with our standard of  
21 living, probably. Tubercular arthritis has almost dis-  
22 appeared because we have streptomycin.

23 THE COMMISSIONER: Thank you. Mr.  
24 Kennedy, we will hear from you again.

25 MR. KENNEDY: Mr. Chairman, I should say  
26 that it makes one feel just a little bit humble to take  
27 this position to deal with some medical matters after  
28 hearing Dr. Swanson and the obvious qualifications which  
29 he has.

30 THE COMMISSIONER: I thought the same way





1 when I was asking questions, so don't be embarrassed.

2 MR. KENNEDY: However, I am very happy  
3 that the Commission has seen fit to bring people like  
4 Dr. Swanson here, because I can only think it can be  
5 very helpful certainly not only to the Commission but  
6 all who heard him.

7 I might say that I have Mr. Hall with me,  
8 who is the Compensation Officer for our organization,  
9 dealing with all our compensation cases for the eastern  
10 provinces in Canada, but particularly with the Ontario  
11 cases which we<sup>have</sup>/for members of our organization and others.  
12 Also, Mr. Thibault, who has also done considerable work  
13 on compensation and is a Regional Director of our Union.  
14 In various points of our submission, they will probably  
15 be assisting me in our presentation.

16 What we have to deal with at this time,  
17 Mr. Commissioner, starts on page 1 of our brief. These  
18 are parts which we have not read into previously, they  
19 have not been put into the record.

20 PRE-EXISTING CONDITIONS

21 Many vexing problems in the adjudication  
22 of claims turn upon the Board's practice in estimating  
23 the nature and degree of an injury aggravated by a pre-  
24 existing condition. The Report of the Honourable Mr.  
25 Justice Roach dated May 31, 1950, graphically illustrates  
26 the principled position of this Union in this regard,  
27 when he states on page 46 of his report:

28 "INJURIES AGGRAVATED BY A PRE-EXISTING PHYSICAL  
29 CONDITION

30 Illustration: A workman suffering from diabetes may  
suffer a very minor injury to a toe due to a weight





1 falling on it. His diabetic condition aggravates that  
2 injury and it becomes so serious that the whole foot has  
3 to be amputated.

4 The Board informed me that in the case  
5 illustrated, it would consider the loss of the foot as  
6 having been partly caused by the pre-existing diabetic  
7 condition and would award to the workman only fifty  
8 per cent of the amount which would normally be awarded  
9 to him for the loss of a foot.

10 In my opinion, such a policy is not  
11 authorized by the Act.

12 Section 2(1) provides that compensation  
13 shall be awarded for injury caused by accident. In the  
14 case illustrated, the loss of the foot was not caused  
15 by the diabetic condition within the meaning of those  
16 words in the section. It is true that without the pre-  
17 viously existing diabetic condition, the workman would  
18 not have lost his foot, but the real and effective cause  
19 of the ultimate injury was the weight falling on the  
20 toe, and not the diabetic condition.

21 All workmen are entitled to the full  
22 protection of the Act without any discrimination based  
23 on their physical condition. One or two illustrations  
24 will show why this must be so.

25 Two workmen are struck on the head by a  
26 falling object. One suffers a fracture of the skull,  
27 the other does not. The one who was injured was found  
28 to have a thin skull. Obviously, he should not be  
29 penalized on that account.

30 The workman with the abnormally sensitive







1 skin is incapacitated by hot water and soda used to wash  
2 crockery. The Court of Appeal in England in the case  
3 of Dotzaner v. Strand Palace Hotel Ltd. (1910) 3 Burr-  
4 oughs Workmen's Compensation Cases, page 307, held that  
5 was an accident and the workman should not be penalized  
6 because he had tender skin.

7 The result is no different where the work-  
8 man is suffering from a pre-existing condition. If the  
9 injury aggravates the disease to the point where the work-  
10 man is incapacitated, he is nonetheless entitled to be  
11 fully compensated. In Lloyd v. Sugg & Co. (1900)  
12 L.K.B. 481, the Court of Appeal in England held that a  
13 workman who suffered an injury to his forearm, which  
14 was aggravated by a pre-existing gouty condition, was  
15 nonetheless entitled to compensation and that the pre-  
16 existing gouty condition was immaterial in determining  
17 the amount of the award.

18 To insure that section 2(1) shall be  
19 given its proper application, I recommend that the  
20 following be added as subsection 5 of section 2:

21 "(5) Where an accident causes any injury  
22 to a workman and that injury is aggravated  
23 by some pre-existing physical condition  
24 inherent in the workman at the time of  
25 the accident, the workman shall be compen-  
26 sated for the full injurious result save  
27 only where the pre-existing physical con-  
28 dition is due to an injury for which the  
29 workman is then receiving compensation or  
30 was at some earlier date receiving compen-  
sation which has been commuted."





1 The report of the Hon. Gordon McG. Sloan,  
2 Chief Justice of British Columbia, relating to the  
3 Workmen's Compensation Act and Board, dated February,  
4 1952, further buttresses the position of this Union when  
5 it states on Pages 87 and 88 under the heading Neurosis:  
6 NEUROSIS

7 I understand a neurosis to mean (in short)  
8 a functional disease of the nervous system unaccompanied  
9 by any demonstrable structural changes. The manifesta-  
10 tions thereof range from slight irrational reactions to  
11 a deep-seated psychosis disabling in its effect. In  
12 compensation administration, it is a condition encountered  
13 consequent upon an accidental injury.

14 In 1942, after a review of the authorities  
15 upon the matter, I said (in part):-

16 It will be noted from the foregoing  
17 authorities that under section 7 of the Act, an incapac-  
18 ating neurosis occasioned by physical injury or even by  
19 shock alone, is deemed to be compensable as a 'personal  
20 injury by accident.' There seems to me to be a sound  
21 foundation for that opinion (if I may say so, with  
22 deference), because in my view, any other conclusion can  
23 only be supported on the theory that compensation should  
24 be paid to those men who were, before the injury, perfect  
25 specimens of humanity, both physically and mentally,  
26 and must be refused those who, when employed, suffered  
27 hidden weaknesses in their physical and mental makeup,  
28 so that for them the accident was not the direct cause  
29 of their incapacity but merely the 'occasion' or the  
30 'exciting' cause of it. Such a theory has no place in  
compensation law as I understand it.



1 The benefits of compensation are not  
 2 limited to the normal man but are available to any man  
 3 who suffers 'personal injury by accident' within the  
 4 wide interpretation of which 'accident' is susceptible  
 5 under the Act.

6 I can see no distinction in legal  
 7 principle in interpreting 'accident' between the case of  
 8 one man suffering from a predisposing cause, physical in  
 9 its nature, and that of another predisposed to an in-  
 10 capacitating neurosis because of some latent defect in  
 11 his personality. Whatever the aetiology of the physical  
 12 or mental predisposition, the precipitating cause is the  
 13 accidental injury.

14 It is my view then, it has been authori-  
 15 tatively decided that disabling neurosis, whether caused  
 16 directly by the accident, or 'occasioned', 'excited',  
 17 'precipitated', or 'contributed to' by the accident, is  
 18 a personal injury by accident within the meaning of  
 19 section 7 of the Act and, as such, is compensable."

20 In a similar vein, the Report of the  
 21 Honourable W.F.A. Turgeon, P.C., inquiring into the  
 22 Workmen's Compensation Act of the Province of Manitoba,  
 23 1958, has this to say on pages 66 and 67 of his report:

24 "Bordering on this kind of case although  
 25 not wholly assimilable to it, is the condition of the  
 26 workman who has, by reason of a defective physical con-  
 27 dition, a pre-disposition to injury or death arising  
 28 out of the nature of his employment. An instance of  
 29 this kind is to be found in the American case of Town  
 30 of Cicero vs. Industrial Commission (Supreme Court of







1 Illinois (1949) 404 111.487, 89 N.E. 2d, 354)

2 In this case one Miller, a lieutenant in  
3 the fire department of Cicero, had suffered from heart  
4 disease, (chronic myocarditis) for at least five years  
5 prior to his death. He had been advised by his physician  
6 that he should quit his job because it was too strenuous  
7 for him. On the morning of January 22nd, 1946, a fire  
8 occurred at a restaurant near the station where he was  
9 on duty. He rushed to the fire by truck, ran into the  
10 building and began directing his men in the extinguish-  
11 ment of the fire. Suddenly he fell to the floor, was  
12 taken to a hospital and was found to be dead. In dis-  
13 posing of the case, the court said that the rule to be  
14 followed, was "that if a workman's existing physical  
15 structure, whatever it may be, gives way under the stress  
16 of his usual labour, his death is an accident which  
17 arises out of his employment.

18 The English decisions in similar cases are  
19 to the same effect: Glover, Clayton & Co., vs. Hughes  
20 (1910) A.C. 242; Partridge Jones and John Paton Ltd.,  
21 vs. James (H.L.) A.C. (1933) 501. In the first of these  
22 two cases, the facts are said to be these.

23 A workman who was suffering from a  
24 serious aneurism, was employed on tightening a nut by  
25 a spanner when he fell down dead. The County court judge  
26 found the death was caused by a strain arising out of  
27 the ordinary work of the deceased operating upon a con-  
28 dition of body which was such as to render the strain  
29 fatal, and this House --- Lord Atkinson and Lord Shaw  
30 dissenting --- held that it was a case of personal injury





1 by accident arising out of and in the course of the  
2 employment."

3 The complete unanimity of opinion expressed  
4 by the eminent Jurists lends strong support to our Sub-  
5 mission that the recommendation of Justice Roach pre-  
6 viously referred to be incorporated in Section 3 of the  
7 Act.

8 At this point, before I go on, I would  
9 ask Mr. Hall to make some observations as he has been  
10 handling most of these cases for our organization.

11 MR. HALL: Mr. Commissioner, I am  
12 awful hard put, as Mr. Kennedy has expressed in his  
13 remarks, to follow the physicians and the presentation  
14 made by Dr. Swanson, and many of the points that I had  
15 intended to deal with on the matter of pre-existing  
16 conditions, particularly as they apply to arthritis  
17 and the relationship of repetitive stress and strain,  
18 have been dealt with in an able manner by Dr. Swanson,  
19 and I find it very difficult to add anything in this  
20 regard.

21 However, apart from the effect of  
22 repetitive stress, as it relates to arthritis, it has  
23 been a noteworthy experience in examining the claims  
24 to draw certain conclusions with regard to cumulative  
25 injuries associated with cumulative stress and strain  
26 in employees, and I share the remarks made previously  
27 in the other presentation of briefs where the emphasis  
28 was placed on the cumulative effect of injuries. It is  
29 not an uncommon experience in my work to deal with  
30 claimants who, over a five-to ten-year period, had been





1 involved in five or six injuries, low back injuries,  
2 sometimes at the cervical level, where you have a re-  
3 petitive condition which is described as strain or  
4 sprain or soft tissue injury. Notwithstanding the  
5 recuperative powers of the human organs, and particularly  
6 the spine, nevertheless, it is the common experience  
7 that four or five such injuries which are characterized  
8 as soft tissue injuries, lumbar strain, the workman quite  
9 often winds up with the jackpot and ends up with a pro-  
10 truded disc or herniated disc. On the basis of the  
11 lumbar stress, I would suggest, with all deference to  
12 the legal profession that lumbar diagnoses are not  
13 diagnoses but educated guesses, that decisions in  
14 adjudication which rule out the cumulative effect of  
15 repetitive injuries of a stress and strain character  
16 are not consistent with such knowledge I have of science,  
17 physics, where all of life is a question of quantitative  
18 growth and a question of leaps of quantitative develop-  
19 ment. I repeat that injuries which are followed by  
20 herniations and so on are inseparably related to  
21 cumulative stress.

22 In dealing with neurosis, I would like  
23 to quote three small sections from a book, "Pain. Its  
24 Mechanisms and Neurosurgical Control", by Dr. <sup>James</sup> C. White  
25 and Dr. William H. Sweet. Dr. White is Chief of  
26 Neurosurgical Service of the Massachusetts General  
27 Hospital, and Associate Professor of Surgery at Harvard  
28 Medical School. There is a specific section dealing  
29 with psychiatry, Chapters 4 and 10, and I would like  
30 to quote sections from Chapter 4 on Page 104 and page







1 106. Under the Chapter headed "The Neurotic Components":

2 "One often hears a physician say of his  
3 patient that 'he imagines his pain'. In  
4 our experience with psychoneurotic  
5 patients we are inclined to think that  
6 this is rarely if ever true. Some pain,  
7 however slight, is almost always at the  
8 basis of the painful reaction. It may be  
9 neurotically exploited by exaggeration  
10 and introspection, so that the incapacity  
11 it causes is out of all proportion to  
12 the original pain. But in most cases,  
13 the pain was there and its combination  
14 with anxiety made possible the neurotic  
15 reaction which led to consulting a  
16 physician."

17 In making these quotations, I am not  
18 trying to quote out of context. I am merely doing this  
19 to save time. On page 106, in the last paragraph:

20 "Pain and suffering are not synonymous.  
21 Pain is only a part of the suffering  
22 undergone by the patient. It may be a  
23 large part, or it may be a small part.  
24 To evaluate this is the important task  
25 of the psychiatrist. A mild pain may  
26 cause much suffering because of what it  
27 means to the patient."

28 Here, of course, I would like to emphasize  
29 this particular section because it is more applicable  
30 to the type of individual and the type of motivation of





1 the people we are dealing with in this industry.

2 "Men who have been exceptionally robust  
3 and healthy, leading active lives, may  
4 be thrown into a fit of fear by a sudden  
5 illness with pain."

6 And the last quote I would like to make  
7 is on page 104, at the top:

8 "A malingerer knows perfectly well that  
9 he is faking; A psychoneurotic patient  
10 is more or less unaware of his motiva-  
11 tion - it is unconsciously motivated to  
12 a much greater extent than is the case  
13 of the malingerer. But even the malin-  
14 gerer who is perfectly conscious of his  
15 faking may not understand what drives  
16 him to behave in this way, so to some  
17 extent his motivation is unconscious,  
18 and he is to be looked upon as suffering  
19 from psychopathological reactions."

20 I made these quotes, Mr. Commissioner,  
21 to underscore something that Dr. Swanson dealt with in  
22 his concluding remarks. While we recognize that in  
23 development of the insurance principle embodied in the  
24 Act and the development of the actuarial figures re-  
25 quired for assessment, it is necessary to treat with  
26 averages, I submit, Mr. Commissioner, that the fundam-  
27 ental position of compensation is as has been expressed,  
28 the question of justice for the workman, in compensating  
29 him for the injury he has received, and the basic  
30 principle, the method of operation of our Board in





1 Ontario and from what I have read in the various Acts  
2 throughout Canada, it is justice for the individual,  
3 and the individual is unique. Even in the case of  
4 identical twins, there are unique differences, and in  
5 dealing with pre-existing conditions, we are dealing  
6 with the uniqueness of the individual.

7 While it is true that perhaps the doctor,  
8 the physician, the researcher in his etiological  
9 approach has approached it from a different point of  
10 view than from the practitioner in a court of law, the  
11 fact is that both of them are dealing with an individual,  
12 and it is submitted that in this context the physician  
13 as expressed by Mr. Justice Roach, confirmed by Mr.  
14 Justice Sloan, Mr. Justice Turgeon, takes this into  
15 account.

16 I have been advised by Mr. Kennedy, who  
17 was here at the earlier session - I was not able to  
18 attend due to illness - that some of the submissions,  
19 I believe particularly the submission of the Mining  
20 Association, emphasis was placed upon the very rigorous  
21 character of the medical examination for an individual  
22 who is going to work in the mining and metallurgical  
23 industry, and we think it is apt and appropriate that  
24 the position expressed by Mr. Justice Roach and the  
25 other jurists I have referred to has a relationship to  
26 the rigorous examination for people in this industry.  
27 But they remain the cream of the crop, so to speak,  
28 physically, I have found in the mining and metallurgical  
29 industry, and even within this crop, nevertheless, we  
30 have the uniqueness of the individual. To approach the







1 question merely on the basis of etiology by the medical  
2 profession - and I am not here being critical of the  
3 medical profession - to take the basis for the computa-  
4 tion of the question on etiology does not take into  
5 account the individual in his work.

6 I might make one observation in closing  
7 my remarks, Mr. Commissioner. From my understanding of  
8 the claims experience of the Board, some 96 percent  
9 are adjudicated favourably on behalf of the claimant.  
10 It is our experience that the majority of claims that  
11 are not adjudicated favourably in the main - and we  
12 have no statistical figures to offer in this regard;  
13 it is merely an observation - the majority of people  
14 who have difficulty in establishing claims are generally  
15 in the occupational classification of a miner, a driller,  
16 that the majority are bonus workers, and this, too, is  
17 related to the uniqueness of the individual.





1 THE COMMISSIONER: Related to what?

2 MR. HALL: Related to the uniqueness of  
3 the individual. It takes a specific type of individual.  
4 I believe Dr. Swanson pointed out that the people who  
5 are emotionally unstable in their study had been weeded  
6 out by the selective process by not being able to work  
7 in this environment and that under these conditions we  
8 consider it honourous that the recommendations of the  
9 eminent jurists do not appear as part of the statutes  
10 in the Act.

11 THE COMMISSIONER: What are bonus workers?

12 MR. HALL: As opposed to people who are  
13 working underground on an hourly basis. I will let  
14 Mr. Thibault answer that.

15 MR. THIBAUT: Incentive workers, they  
16 work on an incentive where they get extra for every-  
17 thing above the normal.

18 THE COMMISSIONER: They work on the  
19 incentive plan according to their production or some-  
20 thing?

21 MR. THIBAUT: More production beyond  
22 the norm, which is the normal effort, the more pay.

23 THE COMMISSIONER: Anything beyond that  
24 is incentive pay?

25 MR. THIBAUT: Yes, more commonly called  
26 the speed-up system.

27 THE COMMISSIONER: That is common in  
28 the mining industry, is it?

29 MR. THIBAUT: Yes.

30 MR. HALL: Under these conditions, we





1 feel that the lack of the appearance of the recommenda-  
2 tions of Mr. Justice Roach, Justice Sloan and Justice  
3 Tysoe in the statutes militates against this most  
4 productive section of our industry and this is not to  
5 disparage the people who are working in the low sections,  
6 the mine sections and the trades because they, too,  
7 working in their peculiar environment make their con-  
8 tribution and too will get benefit from the incorpora-  
9 tion of the recommendations of the justices.

10 That is all I have to say, Mr. Commissioner.

11 THE COMMISSIONER: I think we will adjourn  
12 for ten minutes.

13 ---Short Recess.

14 MR. GUTHRIE: Mr. Kennedy, would it  
15 interrupt your presentation if we dealt with that section  
16 before you go on to something else?

17 MR. KENNEDY: No, I don't think so.

18 MR. GUTHRIE: I just wanted to be clear  
19 on this portion of your brief. As I see it, your  
20 position is substantially the same as that of the Steel-  
21 workers with this exception, that you have introduced  
22 this question of neurosis which does not appear in their  
23 brief, but leaving that aside for the moment, as I  
24 understand your brief, you ask the Commission to adopt  
25 the position taken by Mr. Justice Roach and the other  
26 Commissioners who have reported on this matter, Mr.  
27 Justice Roach, Mr. Justice Sloan, and Mr. Justice  
28 Tysoe.

29 . KENNEDY: That is correct.

30 MR. GUTHRIE: None of whose recommenda-







1 tions have so far been adopted in the provinces where  
2 they have been reported, is that so?

3 MR. KENNEDY: I think Mr. Hall can speak  
4 on that as to whether they have actually been adopted  
5 or there has been any change in the actual dealings by  
6 the Board on some of these cases. Mr. Hall would be  
7 more familiar with that.

8 MR. GUTHRIE: Can you help us on that,  
9 Mr. Hall?

10 MR. HALL: It has been my experience -  
11 of course, I can't say this with the authority that  
12 perhaps the members of the Board could, but it appears  
13 to me that the decision expressed of 50 percent re-  
14 sponsibility is advanced more on 75 percent based on the  
15 individual merits of the case and a far greater allow-  
16 ance has been made. However, I can't speak with author-  
17 ity on this because I do not have statistical information  
18 which I am quite sure the Board has in this regard.

19 MR. GUTHRIE: When you say the 50 percent,  
20 you are speaking of the cumulative situation, the man with  
21 diabetes and that type of thing?

22 MR. HALL That is right. However, I  
23 am inclined to think that there has been in general  
24 a more liberal attitude in the application. I believe  
25 the direction is beyond the 50 percent.

26 MR. GUTHRIE: The changes have been not  
27 in legislation --

28 MR. HALL: But in practice.

29 MR. GUTHRIE: In policy, yes. Can you  
30 help us, Mr. Hall, on any experience you have had with





1 the Board here on this question of repetitive sprains  
2 or strains leading to the cumulative effect that you  
3 spoke of? Could you be more specific as to the Board's  
4 approach to those cases?

5 MR. HALL: I would say since the incorpora-  
6 tion of Section 3 and the definition of accident, that  
7 since 1963 there has been more favourable adjudication  
8 in respect of injuries arising out of and in the nature  
9 of the occupation, that there has been a much more  
10 liberal attitude to this. If I could, perhaps, explain  
11 it in this way: It has been referred to by other briefs.  
12 I believe there was some reference to this indirectly  
13 by the chiropractors in developing the cause of an  
14 accident. For example, I could put it this way: A  
15 miner or a driller is working during the course of the  
16 day and, in the course of his work, he may have been  
17 involved in lifts of timbers up to 150 or 200 pounds.  
18 At the time, he feels a wrench. However, he is accustomed  
19 to working with aches and pains during the course of the  
20 day and doesn't pay any particular attention to it.  
21 Perhaps on his way to lunch in the morning, he may  
22 notice that his back has really stiffened up and he is  
23 beginning to experience acute spasmodic pain. That pain  
24 did not occur at the point of the experience of lifting  
25 and so on and so forth, but some hours later.

26 It has been my experience that under  
27 these circumstances when the relevant work history for  
28 the day has been enunciated and the relationship has  
29 been shown to the occupation that favourable adjudication  
30 has been granted in this regard and it is in this conn-





1 ection that I note the greatest advance. As to the  
2 adjudication arising out of repetitive stress over a  
3 long period of time, eight, nine, ten years, it has been  
4 my experience that in the main, adjudication is based  
5 upon the principle of aggravation of a pre-existing  
6 condition.

7 MR. GUTHRIE: In those cases, presumably  
8 there would be no medical record or Board record of the  
9 many little sprains and strain incidents?

10 MR. HALL: They arise out of the very  
11 nature of the occupation.

12 MR. GUTHRIE: They would not have been  
13 important?

14 MR. HALL: No. But, in relation to a  
15 particular work day - and I have seen occasions where  
16 such an incident has been, we will say for example,  
17 reported on the Monday following the last shift which  
18 would be a Friday, that where they have been able to  
19 establish non-medical statements or evidence from  
20 workmen and/or supervisors and/or first-aid records that  
21 something did happen, that even although there was a  
22 time lapse from Friday to Monday, that on occasion a  
23 favourable adjudication has been made in this regard  
24 but it is essentially a question of establishing the  
25 work history, the injury arising out of the work history.

26 MR. GUTHRIE: In this area then, you are  
27 not raising <sup>any</sup> / great complaint about the manner in which  
28 these are dealt with by the Board, am I right?

29 MR. HALL: Other than our position on  
30 pre-existing conditions where you have the triggering of







1 an injury which is incapacitating and when the Board,  
2 in its adjudication, determines that X percentage of  
3 the disability can be related to the causes which pre-  
4 exist the industry, a payment is not made because the  
5 Board has determined and to quote a previous brief, I  
6 think, where the man's body itself was the culprit,  
7 that under these conditions we do disagree with the  
8 Board's practice.

9 MR. GUTHRIE: Is there any tendency to  
10 move away from the 50 percent to 75 percent?

11 MR. HALL: I gather that, although I  
12 can't speak with authority on it, but there is some  
13 indication in the cases that I have handled that this  
14 is so.

15 MR. GUTHRIE: Then, could I move to this  
16 question of neurosis for a minute. At page 5 of your  
17 brief, quoting from the Sloan Report, you speak of a  
18 disabling neurosis. Again, could you tell us what your  
19 experience has been with the way the Board deals with  
20 that situation?

21 MR. HALL: Not in my experience have I  
22 had one particular case where the neurosis was of  
23 the -- the cause of the disability, a particular dis-  
24 ability was neurotic in its essence. I have not, in  
25 my experience, ran up against this. Where I have,  
26 however, run into it is where, as a result of the injury,  
27 there has been difficulty in the rehabilitation of the  
28 individual; in other words, it has been decided  
29 medically that the pain is psycho-genic in origin,  
30 and the Board's practice is to pay a portion, in other





1 words, partial disability in this regard and to take  
2 the position that, here again, the man's organism, his  
3 mental processes, his inherited tendencies or perhaps  
4 his experience and his pre-history in life have been a  
5 portion of the problem and, in this connection, we, of  
6 course, find ourselves at odds with the Board's practice  
7 in this regard.

8 MR. GUTHRIE: The Board's practice is to  
9 encourage some improvement in the condition?

10 MR. HALL: That is correct, we share with  
11 the Board the necessity and the efficacy of rehabilitation  
12 of workmen. I read the particular section dealing with  
13 neurosis and I would like to place particular emphasis  
14 on the mental effect upon the person who is <sup>a</sup> normally  
15 robust and physically active person, the impact and effect  
16 of trauma on people of this type which is much greater  
17 quite often than the effect on a person whose pursuit  
18 is intellectual. I am only generalizing, of course.  
19 Perhaps to a certain extent, I am defeating some of my  
20 other remarks.

21 MR. GUTHRIE: In these cases, do you find  
22 that the Board calls for reports from psychologists and  
23 psychiatrists?

24 MR. HALL: Yes, there have been references,  
25 some are referred for psychiatric assessment.

26 MR. GUTHRIE: Is that common in your  
27 experience?

28 MR. HALL: Where it is indicated, the  
29 Board accedes to this and has the claim assessed.

30 MR. GUTHRIE: Then, if I understood you,





1 I believe it is your belief, although not supported by  
2 statistics, that a majority of rejected claims are of  
3 miners on incentive pay?

4 MR. HALL: It is our experience that  
5 people engaged in productive mining - and this, of  
6 course, includes some people who are not bonus miners -  
7 but bonus miners to a large extent, and we attribute  
8 this, of course, to the motivation of the workman, we  
9 have found from experience that their pain thresh-  
10 hold is high because of their concentration on getting  
11 the muck out, so to speak, the motivation is extremely  
12 strong.

13 MR. GUTHRIE: Do you base this on the  
14 back problem or on the neurosis?

15 MR. HALL: There is a relationship to  
16 both. A person, who, we will say, has ten years as  
17 a production miner accustomed to driving to getting  
18 that muck out to getting to work every day, who has had  
19 no appreciable history of disabling injuries other than  
20 minor ones, and then he has an experience, an injury,  
21 the trauma is not only related to his physical body  
22 but also to his intellectual processes.

23 MR. GUTHRIE: But you have no statistics  
24 within your industry concerning that?

25 MR. HALL: No, unfortunately, I don't.

26 MR. GUTHRIE: I think that is all, thank  
27 you.

28 MR. KENNEDY: The next part of our brief  
29 for this part of the agenda, Mr. Commissioner, starts  
30 at page 12. It is sub-headed "Silicosis".







1 This Union, by convention action, unani-  
2 mously endorsed the recommendations of the Committee on  
3 Silicosis, appointed by the Associated Compensation Boards  
4 of Canada. Such recommendations were made in 1961, and  
5 are set forth hereunder.

6 RECOMMENDATIONS OF SILICOSOS COMMITTEE

- 7 1. A minimum exposure period of two years.  
8 2. That there be no time limitation for filing of claim.  
9 3. That all present limiting clauses as to residence  
10 should be abolished.  
11 4. That adequate work records of all miners be kept  
12 and all such records be filed with the appropriate  
13 Department of Mines should a particular mine cease  
14 to operate.  
15 5. That adequate pre-employment chest examination,  
16 including x-ray, should be established.  
17 6. That each employee should have an adequate annual  
18 re-examination.  
19 7. That there should be periodic dust counts and  
20 adequate control measures.  
21 8. That authority under the respective Acts be given  
22 to each Board to make agreements with each other  
23 with respect to claims where there has been exposure  
24 in more than one Province.

25 I might say, Mr. Commissioner, that this  
26 was a meeting of the Associated Boards from all Provinces  
27 in Canada, and you will note that one or two of the  
28 recommendations are not applicable to Ontario as far  
29 as x-rays and annual examinations are concerned because  
30 they are already in effect in this Province, but they





1 were recommending for all Provinces at that time.  
2 However, the question of the exposure period, the limita-  
3 tion on filing of claim, these are new. The periodic  
4 discounts and the reciprocal arrangements which we will  
5 deal with further on in our brief, are a very,  
6 very strong part of our submission, that there should  
7 be complete reciprocity between all Provinces for work-  
8 men who may work in every Province in Canada.

9 THE COMMISSIONER: That is what I was  
10 going to ask you about. These recommendations, have  
11 they been adopted by other Provinces?

12 MR. KENNEDY: They have not been adopted  
13 in full in other Provinces and, particularly, with  
14 reciprocity, Mr. Chairman, they have not been adopted  
15 but we feel this is a most urgent situation and we  
16 realize that in your recommendations, Mr. Commissioner,  
17 you could perhaps only follow a recommendation of other  
18 Commissioners because this is something that cannot be  
19 enacted solely by the Province of Ontario, but I think  
20 the stronger recommendations we get may bring about the  
21 situation where there is complete reciprocity.

22 Mr. Thibault points out that a number  
23 of provinces, in fact, most of them, have dealt with  
24 this by enabling legislation allowing this to take place.  
25 However, it has not been finalized yet and I don't think  
26 Ontario or Manitoba have yet passed the enabling legis-  
27 lation and Quebec to allow the provinces to reach this  
28 reciprocal agreement.

29 THE COMMISSIONER: They have passed  
30 enabling legislation, but they have not done anything





1 about proceeding on it?

2 MR. KENNEDY: I suppose all provinces  
3 would have to pass the enabling legislation, Mr.  
4 Commissioner, in order that the agreements could be  
5 effected.

6 THE COMMISSIONER: What there is to be  
7 put in effect in one place, it should be put into effect  
8 in all?

9 MR. KENNEDY: Yes, that is right. Once  
10 they are accepted by all the Provincial Legislatures  
11 then they can become effective. In fact, the next part  
12 of our brief goes on to that.

13 The adoption by all provinces of these  
14 recommendations will remove many of the difficulties  
15 experienced by workmen in the Canadian mining and  
16 metallurgical industry, in establishing their just  
17 entitlement to benefits arising out of silicotic disabil-  
18 ity. We wish to emphasize that the lack of reciprocal  
19 arrangements as recommended by the Silicosis Committee  
20 is a serious barrier in establishing entitlement for  
21 many workmen who follow their vocations in the mining  
22 and metallurgical industry and who move very frequently  
23 from province to province quite often for the same  
24 employer. Such employment mobility is very common in  
25 the Diamond Drilling and Shaft sinking aspects of the  
26 industry.

27 I would like to comment on this, Mr.  
28 Commissioner, that in this branch of the mining industry  
29 there are what we call shaft and development contractors  
30 or diamond drilling contractors and many of these con-







tractors will operate in every province in Canada where there is mining. Some individual may spend his entire life working for this employer, but because of the fact that it is on a contract basis he may work for a year and a half in Ontario, for the employer, move on to Manitoba, then move on to British Columbia and come back to Ontario but spend all of his life for the same employer, but the lack of the reciprocal arrangement can deny that man compensation if he develops silicosis or some other industrial disease.

THE COMMISSIONER: Limiting clauses as to residence should be abolished. That is really the one you are emphasizing, I suppose?

MR. KENNEDY: Yes, and, of course, the fact that the man has contracted silicosis in the industry where he has never worked in any other industry and there should be no doubt as to his qualifications if he develops or contracts silicosis.

We are aware, Mr. Commissioner, that the adoption of these recommendations still provide limitations with regard to the period of exposure, but we note that the Board has broad discretionary powers in Subsections (3) and (4) of Section 72 to deal with silicotic claims in special circumstances where a minimum exposure of less than two years may apply. We strongly urge, Mr. Commissioner, that you concur in the aforementioned recommendations.

#### EMPHYSEMA AND BRONCHITIS

We recommend these conditions also be added to the Schedule of Industrial Diseases. Recent studies indicate that amongst workers with x-ray findings





1 of silicosis, there is an incidence of Bronchitis double  
2 that of fellow workers, (See the Report McIntyre Research  
3 Foundation Conference 1963, page 24.) and I filed a  
4 copy of that with the Commission on August 16th, Mr.  
5 Commissioner.

6 In a paper presented by G.W.H. Schepers,  
7 M.D., D.Sc. at the Eighth Conference of the McIntyre  
8 Research Foundation, October 1956, on page 16 it is  
9 stated:

10 "For every welder with mere ferrous pig-  
11 mentation of his lungs, there may be another  
12 with associated pulmonary emphysema."

13 On page 27 of the same report, the follow-  
14 ing significant statement is made:

15 "The problem is entirely different when  
16 emphysema manifests itself at an early  
17 stage in the pneumoconioses or even before  
18 there are signs of the lung changes  
19 commonly admitted to be ascribable to the  
20 injurious action of the inhaled dust."

21 THE COMMISSIONER: What is Emphysema?

22 MR. HALL: I understand, Mr. Commissioner,  
23 it is a distension of sections of the lung which make  
24 for difficult breathing. I can't claim to be an author-  
25 ity on this disease.

26 THE COMMISSIONER: Something like Asthma?

27 MR. HALL: There is a shortness of breath,  
28 but I don't believe it is in the same context as Asthma.

29 MR. GUTHRIE: Dr. Sutherland will be  
30 dealing with that at some length today, sir.





1 MR. KENNEDY: "For long the latter forms  
2 of emphysema have been rejected as non-occupational,  
3 coincidental occurrences. Some may be idiopathic dis-  
4 orders. The growing evidence furnished by laboratory  
5 experimentation favors the concept that most emphysema-  
6 tous states in workers in dusty occupations are of  
7 pneumoconiotic origin. Experiments on the effect of  
8 arc welding, hermatite dust, bituminous coal dust, oil  
9 smoke, chert dust, beryllium and rare earth fluoride  
10 dust (Schepers 14, 17, 22, 34, 35, 43, 44, 45) have  
11 brought to light that dust-caused emphysema, either  
12 hypertrophic or focal or both, may precede the focal  
13 accumulation of inhaled particulate matter."

14 RHEUMATISM AND ARTHRITIS

15 I don't know if I have to read this.  
16 It was read into the record and dealt with this morning.  
17 I will go on to Blanket Coverage for All Industrial  
18 Diseases.

19 We recommend that the Act be amended to  
20 provide for compensation for any diseases or disabling  
21 conditions caused directly or indirectly by the nature  
22 of the employment and further that the removal of  
23 residence qualifications, time limits, etc., previously  
24 referred to in the section dealing with Silicosis,  
25 apply to this recommendation.

26 In this connection, we submit for your  
27 consideration a copy of our Submission to the Turgeon  
28 Commission, Manitoba, 1957, page 11 through to page 54,  
29 containing a paper read before the Eighth Conference  
30 of the McIntyre Research Foundation, Toronto, Ontario,  
October 1956. In particular, the sections dealing with







1 Etiology, Pathogenesis, and Sequelae reveal a broad  
2 spectrum of industrially related pulmonary diseases  
3 occasioned by dust exposure, fumes and gases. And I  
4 should say, Mr. Commissioner, that it was my intention  
5 at the beginning to read into the record the article  
6 of Dr. Schepers. However, this is a rather lengthy  
7 and technical and very detailed paper and <sup>it</sup> would probably  
8 take me almost two more hours to make my presentation.

9 THE COMMISSIONER: And it is not easy to  
10 understand either, because I have sought to read it.

11 MR. KENNEDY: I am quite sure that you,  
12 Mr. Commissioner, will give full consideration to this.  
13 Therefore, I will refrain from reading it and taking up  
14 the time of the Commission. While I may have some  
15 differences with some medical men who may disagree with  
16 me, in my opinion this work by Dr. Schepers is one of  
17 the most detailed and complete studies of the question  
18 of Silicosis and Industrial Diseases. In this article  
19 he shows that, while most people think that silica dust  
20 is the only substance that may cause disease, I am  
21 referring to laymen when I say "Most people" - neverthe-  
22 less, this article shows that there are thousands of  
23 dust elements and other chemicals that are being  
24 developed by technological advance, new processes and  
25 so forth that may be even more dangerous or just as  
26 dangerous as silica dust. Therefore, on this question,  
27 or on the paper dealt with by Dr. Schepers, I would  
28 merely like to read the conclusions which I personally  
29 drew from a study of the material, and the conclusions  
30 to be drawn from Dr. Schepers' statement can be summar-





1 ized as follows.

2 That even the scientists still have a  
3 great deal to learn on the question of dusts, their  
4 diseases, treatment and possible cure. The great need is  
5 for a continued and intensive research into this very  
6 serious problem.

7 That many dusts which have previously  
8 been overlooked or have not been studied because of lack  
9 of time and resources are extremely dangerous to health  
10 maybe more so than silica.

11 That where the ordinary layman might  
12 have thought that silica dust was the only one which  
13 caused damage, there are thousands of dust fumes and  
14 elements which may cause disease just as harmful or  
15 more harmful than what has up until now been known as  
16 Silicosis.

17 That while aluminum powder may be  
18 beneficial, it is too early to accept this treatment as  
19 a complete deterrent and that because of the disagreement  
20 still existing amongst the experts, a great deal of  
21 research needs to be done in this field as well.

22 I might say, Mr. Chairman, that on the  
23 question of aluminum dust, there is a very general  
24 feeling among our membership that it has been very  
25 beneficial in the prevention of Silicosis, but even the  
26 medical men who are very familiar with this have advised  
27 us that it is still too early to determine whether it  
28 is the aluminum dust, new techniques and the purifying  
29 of air or better ventilation systems under the ground  
30 that, with the combination of all these things, there is





1 marked reduction in the number of silicotic cases which  
2 come to light, but there still has to be a great deal  
3 of research done before they are accepted as being a  
4 complete deterrent.

5 Article 6 - perhaps silicosis should be  
6 eliminated from the schedules and the definition  
7 suggested by Dr. Schepers inserted in its place. That  
8 will be found in Dr. Scheper's article, the definition  
9 that he suggests.

10 The material now at hand proves rather  
11 conclusively that reliance on the x-ray only in diagnosing  
12 dust diseases is not the answer to the problem, as not  
13 enough personnel are available who can take x-rays or  
14 even properly read the result of x-rays.

15 I think in substantiation of that, there  
16 were quotes from the organizations presenting a brief  
17 previously, where this was still the finding of some  
18 of the experts that actually very few people are capable  
19 of giving a complete diagnosis as a result of x-ray or  
20 even reading x-rays properly in the field of silicosis.

21 MR. GUTHRIE: Mr. Kennedy, is that  
22 definition you refer to very lengthy? I wonder if it  
23 could be read, Scheper's definition?

24 MR. KENNEDY: Well, here is the definition  
25 that Dr. Scheper suggests.

26 THE COMMISSIONER: What are you reading  
27 from?

28 MR. KENNEDY: This is at page 13 of the  
29 brief submitted by our Union to Mr. Justice Turgeon  
30 in Manitoba, and I filed that with you too.







1 THE COMMISSIONER: What are you suggest-  
2 ing that it supplant in the present Act?

3 MR. KENNEDY: I don't know if I am  
4 qualified to do that, Mr. Commissioner, but Dr. Schepers  
5 does give this definition, and this is the question that  
6 Mr. Guthrie has asked me.

7 MR. GUTHRIE: I understood you to say  
8 earlier that you would suggest eliminating the silicosis  
9 item and substituting this one?

10 MR. KENNEDY: Well, we said that perhaps  
11 this should be, and this is what Dr. Schepers has to  
12 say:

13 "That pneumiconios denotes any biological  
14 state commencing in or involving the  
15 respiratory organs and resulting from  
16 exposure by inhalation to unusual atmos-  
17 pheric conditions created by technological  
18 changes in the human environment."

19 This was the definition.

20 His suggestion might be more all-encom-  
21 passing than the the definition that is now in the Act.

22 I would like to read some points from  
23 the Manitoba brief which we presented, Mr. Chairman,  
24 and these are for the purpose of showing that a number  
25 of eminent doctors have stated that silicosis itself  
26 is the cause of other diseases which may afflict people  
27 in dusty industries, but which, at the moment, are  
28 neither scheduled or compensated by any compensation  
29 board that I know of.

30 THE COMMISSIONER. If silicosis is





1 responsible for it, would not they come in? You are  
2 talking now about diseases that appear subsequent to  
3 silicosis being established?

4 MR. KENNEDY: Yes.

5 THE COMMISSIONER: Wouldn't it come in  
6 then under the silicosis heading?

7 MR. KENNEDY No, it wouldn't, Mr.  
8 Commissioner, because silicosis is recognized as being  
9 a damage to the lungs. When the lungs become saturated  
10 to a lesser or greater extent by dust particles and  
11 causes natural silicosis. Therefore, we have gone to some  
12 considerable length to get material on this, and this  
13 material shows that because of the silicosis where the  
14 lung may be completely saturated or completely blocked  
15 by the silica that, obviously, it is not able to per-  
16 form the function of cleansing the blood as it should  
17 to go through the rest of the system and when this  
18 is not done, then, of course, some doctors say that  
19 other parts of the body may be affected and, at the  
20 moment they are not in any way recognized as being  
21 associated with silicosis.





1 "We believe that it is now proven beyond  
2 a shadow of a doubt that Silicosis or  
3 the more general term pneumoconiosis is  
4 responsible for diseases of other parts  
5 of the body which very often result in  
6 death and which, at the moment, are not  
7 compensable. That other organs of the  
8 body are also affected by dust diseases  
9 has been attested by a number of leading  
10 authorities.

11 Dr. Edgar L. Collis, formerly His  
12 Majesty's Medical Inspector of Factories  
13 in England, stated that the blood system,  
14 the kidneys and the liver are also damaged  
15 by exposure to silica.

16 Another important part of the body which  
17 is damaged by silica dust is the heart.

18 To quote the American Heart Journal:

19 'Silicosis is an important cause of  
20 heart disease.'

21 Doctor Lanza has stated silicotics often  
22 die with all the symptoms of heart failure.

23 The reason for this is that the more  
24 nodules there are in the lungs, the more  
25 difficult it is for the heart to pump  
26 blood through them. Dr. Lanza also  
27 stated that 'Most silicotics die of some  
28 infectious disease, usually T.B., before  
29 the silicosis itself develops into its  
30 worst stage.'







1 "The study of miners by a Dr. Cummings  
2 showed that miners with silicosis  
3 suffered six times as much from TB as  
4 did miners not having Silicosis.

5 "A Dr. Sappington, editor of 'Industrial  
6 Medicine' states: 'The truth remains  
7 that silica exposure not only causes other  
8 respiratory diseases, but also damage to  
9 the heart, circulatory system and kidneys,  
10 etc.'

11 "Dr. Lanza in speaking to the McIntyre  
12 Research Foundation conference on  
13 Silicosis and Aluminum Therapy, January  
14 30 and 31, 1950, had this to say: 'There  
15 is only one comment that I want to make  
16 about the Chairman's reference to my  
17 knowledge of silicosis is I would not  
18 attempt either any qualitative or quanti-  
19 tative statement, but I say this - that  
20 I do not know nearly as much about  
21 silicosis as I did ten years ago. I  
22 think it is evident to all of you who  
23 have listened to a discussion such as  
24 has been presented today and of work that  
25 is being carried on by organizations like  
26 the McIntyre Research Foundation, or Dr.  
27 Weyl, or Dr. Evans, or Dr. Motley and  
28 others who are working in similar or  
29 related fields, that we are entering into  
30 a completely new phase or era of considera-





1                   ation of this very important occupational  
2                   disease. During the last 30 years we  
3                   have seen a great deal of research along  
4                   the lines of clinical studies and  
5                   diagnoses, as well as in the control of  
6                   the dust hazard in mines and other kinds  
7                   of industry.

8                   'It is the type of investigation that you  
9                   have heard discussed today and which you  
10                  will hear more of tomorrow, as we must  
11                  look for a solution of present day  
12                  problems.

13                  'However, I think that we need to know  
14                  just what we are talking about. Well,  
15                  you say we are talking about the pneumoc-  
16                  onioses in general and silicosis in  
17                  particular. I will then ask you what is  
18                  the pneumoconiosis and I will also ask  
19                  you, what is silicosis? There are  
20                  different definitions of these conditions,  
21                  some of which have received the sanctity  
22                  of legal enactment which ought to make  
23                  them orthodox, but which often adds only  
24                  confusion to the existing states.

25                  'I do not have a satisfactory definition  
26                  of pneumoconiosis. It is much easier  
27                  to propound these questions than to  
28                  answer them and as you all must know  
29                  one of the most difficult things one can  
30                  do is to write a new definition. I





1 presume that probably we might say in a  
2 more or less informal manner that pneumo-  
3 coniosis is a term used to designate  
4 a condition or disease of the lungs  
5 brought about by the inhalation of dust  
6 and characterized by structural changes  
7 of a fibrotic nature and there I stop.  
8 What kind of changes? We may say that  
9 these changes are grouped into two classes,  
10 disabling and non-disabling.

11 With respect to non-disabling pneumo-  
12 coniosis, Dr. Gardner, you may remember,  
13 coined the phrase "benign pneumoconiosis".  
14 From what you might call a practical  
15 common sense point of view that seemed  
16 a pretty good definition. All of us  
17 who were working in this field and partic-  
18 ularly on the clinical end of it, know  
19 what he meant when he said "benign  
20 pneumoconiosis" and yet exception has  
21 been taken to that term that no process  
22 that involves structural changes in the  
23 lungs can rightfully be called benign.

24 Much information has come to us in the  
25 past few years concerning beryllium.  
26 There are many cases of berylliosis or  
27 beryllium poison and a number of these  
28 cases died. Is this a pneumoconiosis?  
29 Our friends across the border have  
30 described a disease which they have







1                   termed "Shaver's disease" because Dr.  
2                   Shaver first described it. It is purely  
3                   occupational. Is it a pneumoconiosis?  
4                   Is it silicosis? The trend is towards  
5                   more research and more information and  
6                   there is an ever-widening concept of the  
7                   range and scope of these conditions of  
8                   occupational origin. I can remember how  
9                   often Dr. Gardner and I have been emphatic,  
10                  that uncombined silica caused a disabling  
11                  pneumoconiosis to which we gave the name  
12                  " silicosis" and with the one exception of  
13                  asbestosis combined silica did not produce  
14                  a disabling pneumoconiosis. We were very  
15                  happy in those days. We had it all  
16                  nailed down. Silicosis was here and  
17                  asbestosis was here and that is all there  
18                  was to it. There was only one trouble  
19                  about it and that is that we were wrong  
20                  and we began to get that impression, of  
21                  course, from some of the things that you  
22                  heard today.

23                "May I say then, that I am very glad to  
24                have had this opportunity of appearing  
25                before this audience and I think American  
26                industry is extremely fortunate in the  
27                research work that is going on, some of  
28                it governmental, some of it private, that  
29                you have heard here today from Dr. Evans,  
30                Dr. Weyl and others who spoke to you. We





1 have got to have the knowledge of what  
2 we are talking about because right now  
3 I am afraid we are not quite sure or  
4 don't know or don't quite know what we  
5 are talking about."

6 I will conclude my remarks, Mr. Chairman,  
7 by saying that what is most evident from the material we  
8 have presented on industrial diseases and silicosis is  
9 that this matter is <sup>not</sup>licked by any means. Even though  
10 there are statistics to show that the recognized cases  
11 of silicosis have become less since the introduction of  
12 aluminum therapy, nevertheless, when you read material  
13 such as from Dr. Schepers, Dr. Lanza and Dr. Collis  
14 and the eminent men who have devoted their life to  
15 this kind of work, when you find there are new gases,  
16 new dust which has not yet been recognized or there  
17 have been no research facilities for people to look into  
18 these questions, then I think it would buttress the  
19 position of all of us who believe that the question of  
20 accident prevention or the prevention of disease should  
21 be put under the Compensation Board, because there we  
22 believe there would be the greatest recognition as to  
23 the dangers and the real problem that this is. But  
24 the main thing is that there is still a great deal of  
25 research to be done and there is a great deal of in-  
26 capacity, men incapacitated, men disabled from disease  
27 related to silicosis and other industrial diseases that  
28 should be compensable, should be covered by compensa-  
29 tion. When we take this position, we are in no way  
30 casting any reflection on the Board turning down cases





1 such as this because the statute at the moment does not  
2 permit them to give full justice to the man who may be  
3 crippled by industry through industrial disease and the  
4 other matters which we have mentioned in our brief this  
5 morning.

6 MR. GUTHRIE: Mr. Kennedy, could we go  
7 back to silicosis on page 12. Do I understand you to  
8 have said that this Committee on Silicosis which brought  
9 in recommendations in 1961 was one formed by action of  
10 all the Boards in Canada?

11 MR. KENNEDY: Yes, either by the Boards  
12 of their own volition or the legislature or the Minister  
13 responsible. There was such a meeting.

14 MR. GUTHRIE: I wonder if we could  
15 look at the recommendations - there are eight of them -  
16 in the light of the Ontario Legislation and deal with  
17 them quickly, so that we know what, if any, statutory  
18 provisions there are.

19 The first one, a minimum exposure period  
20 of two years. Am I not correct in thinking this is  
21 the present position in Ontario under Section 116, Sub-  
22 section (10)?

23 MR. KENNEDY: Yes, that is correct, Mr.  
24 Guthrie. I did mention that in the brief and in my  
25 remarks.

26 MR. GUTHRIE: I appreciate that. I just  
27 thought we might identify them one by one, if we could,  
28 so that we know what we are really left with.

29 MR. KENNEDY: I may say this, that the  
30 discretion which the Board has to grant a pension for







1 something less than three years is good, but if you read  
2 all of Dr. Schepers' material you will find that men have  
3 died from exposure to silica dust in a period of two  
4 months.

5 MR. GUTHRIE: Let's come to that dis-  
6 cretion in a minute. Item 2 is the time limitation for  
7 filing of claims. Is that any different from silicotic  
8 claims? Are we dealing with six months?

9 MR. KENNEDY: No, silicotic claims must,  
10 of necessity, be different from other claims.

11 MR. GUTHRIE: I mean as to what the statute  
12 calls for in the way of a time limit?

13 MR. KENNEDY: No. Where the statute  
14 calls for a six-month time limit on the reporting of an  
15 injury, this would not apply to silicosis because he  
16 may be out of the industry even six months or more before  
17 x-rays reveal silicosis.

18 MR. GUTHRIE: What time limit do you say  
19 applies in Ontario on the filing of that claim?

20 MR. KENNEDY: Well, I believe that it  
21 was after five years. Now, I don't want to make a state-  
22 ment. Perhaps some of the people from the Board would  
23 be exact on this. I could check it.

24 MR. GUTHRIE: The Board representatives  
25 tell me that they will deal with that in some detail.

26 Item 3, the limiting clauses as to  
27 residence. I presume you refer there to sub-section  
28 (10) of 116, which requires that the workman be actually  
29 exposed to silica dust in his employment in Ontario  
30 for upwards of two years.





1 MR. KENNEDY: Yes.

2 MR. GUTHRIE: That is what you refer to  
3 there?

4 MR. KENNEDY: Yes.

5 THE COMMISSIONER: There are at the  
6 moment some reciprocal arrangements, aren't there, in  
7 Ontario and Manitoba, for instance, on these matters?

8 MR. KENNEDY: Yes. Well, this was a  
9 different question, I believe, Mr. Commissioner. If an  
10 employer, if a contractor, for example, is doing a job  
11 in Manitoba, then the workman would have a choice; he  
12 would receive payment from what I believe would be the  
13 most beneficial to him.

14 MR. GUTHRIE: That is under Section 6.

15 THE COMMISSIONER: You don't think that  
16 affects the present limiting clauses as to residence?

17 MR. KENNEDY: Where there are actual  
18 statistics and information on silica, the inhalation  
19 of silica dust has actually caused death in two months,  
20 of course, this is under concentrated absorbtion.  
21 However, it may kill in a much shorter period than two  
22 months and can disable in a much shorter period than  
23 two years.

24 MR. GUTHRIE: In item 4, is this some-  
25 thing we have in Ontario now, the keeping of adequate  
26 work records by the Department of Mines and particularly  
27 where a mine ceases to operate?

28 MR. KENNEDY: Well, I don't know if  
29 there are records kept of men where the mine ceases to  
30 operate. I can't say if there has been any change since





1 the meeting of the associated Compensation Boards, but  
2 obviously it was not being done at that time. They  
3 would be in a good position to know the records  
4 They were from all the compensation boards of the country.

5 MR. GUTHRIE: I would have thought, in  
6 view of our Mining Act, Section 167, there must be  
7 records. There are annual examinations required, and I  
8 would assume records were kept. But I take it you don't  
9 know particularly about that?

10 MR. KENNEDY: They are kept in chest  
11 examining clinics, and I imagine the Board keeps any  
12 records they have for all time. But records of exposure  
13 to silica should be kept, I think.

14 MR. GUTHRIE: Not just records of examina-  
15 tion.

16 MR. KENNEDY: That is right. When the  
17 associated Compensation Boards made this recommendation,  
18 I take it it was for the purpose that if a claim were  
19 made in any province, then the compensation board in  
20 that province would have no difficulty in getting the  
21 records to substantiate that the man had ten, twelve  
22 or fifteen years' experience in the mining industry.

23 MR. GUTHRIE: Moving to item 5, 5 and 6  
24 together, I think we can take it that this is covered  
25 in Ontario.

26 MR. KENNEDY: Yes, that is covered.

27 MR. GUTHRIE: Item 7, what do you say  
28 about that in Ontario? This is a matter for the Depart-  
29 ment of Mines, I assume?

30 MR. KENNEDY: The Department of Mines or







1 the Department of Health on request. It has been pointed  
2 out that if the Department of Health are called upon  
3 they will take dust counts.

4 MR. GUTHRIE: You say it is only at the  
5 moment on request, and it should be compulsory?

6 MR. KENNEDY: Yes. Certainly, I think  
7 if they were under the jurisdiction of the Compensation  
8 Board, they would see that the proper counts were made  
9 and that adequate control measures were established.

10 MR. GUTHRIE: Then, lastly, you come to  
11 this question of reciprocal arrangements. Do you know  
12 in Canada which provinces have the enabling legislation  
13 you spoke of?

14 MR. KENNEDY: Mr. Thibault, I think,  
15 has that.

16 MR. THIBAUT: Newfoundland, Nova Scotia,  
17 Alberta, British Columbia - all, except Quebec and  
18 Ontario.

19 MR. GUTHRIE: All but Quebec and Ontario?

20 MR. THIBAUT: That is my understanding.

21 MR. GUTHRIE: These sections deal  
22 specifically with silicosis, agreements on silicosis,  
23 or are they general in term?

24 MR. THIBAUT: That is enabling legisla-  
25 tion to adopt reciprocal arrangements between the  
26 provinces on the establishment of a miner's claim on  
27 silicosis.

28 MR. GUTHRIE: It is not a section as our  
29 Section 6, Sub-section (8)?

30 MR. THIBAUT: That is right, it is a





1 form of the reciprocal arrangement.

2 MR. GUTHRIE: And these are related to  
3 silicosis and silicosis only?

4 MR. KENNEDY: Yes, this was dealing  
5 specifically with silicosis.

6 MR. GUTHRIE: Then, Mr. Kennedy, could  
7 we come to your comment on page 13 about the use of  
8 Section 72 to deal with silicotic claims in certain  
9 circumstances, and you refer us to Sub-section (3)  
10 which says: "Nothing in Sub-section (1) prevents the  
11 Board from reconsidering any matter that has been dealt  
12 with by it or from rescinding, altering or amending  
13 any decision or order previously made, all of which the  
14 Board has authority to do." You referred also to Sub-  
15 section (4), which reads: "The decision of the Board  
16 shall be upon the real merits and justice of the case,  
17 and it is not bound to follow strict legal precedent."

18 In your experience, have you known the  
19 Board to rely on those sub-sections to reduce the  
20 minimum period in silicosis claims?

21 MR. HALL: No, to my knowledge, this  
22 has not been the case. But in relating some of the  
23 experience we had expressed to us by Dr. Irwin of the  
24 McIntyre Foundation who recounted to us some special  
25 cases of silicotic conditions which were acquired in  
26 a very short period of time, we notice in the Associated  
27 Boards' recommendations that there would be limitation,  
28 and based on our view, based on the experience we had  
29 with the Board, in a special case where silicosis was  
30 acquired in a very short period of time, it was our view





1 that those sections of the Act would cover the unusual  
2 situation.

3 MR. GUTHRIE: I was really interested  
4 to know whether you have any knowledge of them being so  
5 used.

6 MR. HALL: No.

7 MR. GUTHRIE: Moving to the Emphysema  
8 and Bronchitis section, Mr. Kennedy, are you familiar  
9 with the sort of laboratory experimentation Dr. Schepers  
10 was doing? Was that experimentation with animals, do  
11 you suppose?

12 MR. KENNEDY: Yes, I believe there was  
13 some experimentation with animals.

14 MR. GUTHRIE: I expect it would almost  
15 have to be, would it not? I just wondered if there  
16 was any indication that animals experienced the same  
17 emphysema or emphysemas, if there are several kinds,  
18 as humans?

19 MR. KENNEDY: That I can't say definitely.

20 MR. GUTHRIE: It will probably be covered  
21 by Dr. Schepers who wrote us a definition that he pro-  
22 posed for pneumoconiosis, and I am puzzled to know  
23 whether we would be further ahead with that than under  
24 Schedule 3. You will notice Schedule 3, first of all,  
25 lists Item 12, Silicosis, a description of the disease  
26 in column 1, and the process in column 2 is mining or  
27 quarrying, cutting, crushing, grinding or polishing  
28 stone or grinding or polishing metal. If you will notice  
29 Item 8, it is simply pneumoconiosis rather than silicosis,  
30 and I was rather struck by the fact that there is no







1 process opposite that item in column 2 at all, which  
2 would lead me to think that you couldn't be much broader  
3 than that. I am wondering if we are any further ahead  
4 with what you suggested.

5 MR. KENNEDY: Well, of course, when Dr.  
6 Schepers suggests this definition, I suppose he is  
7 making it as good as he possibly can, so that there can  
8 be no doubt that if it is a disease it can be attributed  
9 to the man's occupation, and then it should be compensable.  
10 There would be some doubt, I suppose, in the description  
11 that you have in this. It is when there is so great a  
12 difficulty among very eminent medical people as to what  
13 would be a correct definition, and I am afraid I can  
14 only say that I accept the definition of the word from  
15 the most eminent authority I know.

16 MR. GUTHRIE: Have you any experience  
17 in how the Board looks at these other than silicosis  
18 cases under Item 8 in Schedule 3, when there isn't a  
19 process?

20 MR. KENNEDY: Mr. Hall informs me he  
21 has had no experience of that.

22 MR. GUTHRIE: Coming, lastly, to the  
23 point you make about other diseases elsewhere in the  
24 body which may be caused by or associated with silicosis,  
25 I think you mentioned circulatory and heart disease,  
26 the kidneys, liver and even tuberculosis. Did I  
27 understand you to say that the Board would not recognize  
28 circulatory disease or heart disease if it could be  
29 shown that it could have developed from silicosis?

30 MR. KENNEDY: I know of no case where





1 they have accepted diseases of the liver or the cir-  
2 culatory system because there is difference of opinion,  
3 medical opinion. While I think the preponderance of  
4 opinion is that these organs can be affected, I can  
5 only recall that we made similar statements before the  
6 Commission chaired by Mr. Justice Roach, and there was  
7 some difference of opinion between Dr. Riddell and the  
8 other authorities which we quoted.

9 MR. GUTHRIE: Do you know of cases which  
10 have been turned down by the Board in this particular  
11 area?

12 MR. HALL: We have had cases, for example,  
13 where a workman who had established a silicosis claim  
14 and had died of heart failure, not right side heart  
15 failure, but where the damage was to the other portions  
16 of the heart. In the light of the explanation which has  
17 been made by Mr. Kennedy to me of his study of the  
18 positions that have been expressed, the medical opinions  
19 that have been expressed are to the extent that a person  
20 with a silicotic condition, which is oxygen starvation,  
21 that it has a deleterious effect on other parts of the  
22 system, the kidney, and so on. My only experience has  
23 been of a silicotic who had died, not of right side  
24 heart failure, but of a coronary condition and that  
25 this claim was rejected as not being related to the  
26 silicotic condition. The point Mr. Kennedy is making,  
27 as I understand it, and from my discussions with him,  
28 is that the deleterious effect on the circulatory  
29 system which results in heart failure other than that  
30 which is compensable, and Mr. Kennedy's should be  
compensable and, in our view, this hasn't been the case.





1 MR. GUTHRIE: If it were established by  
2 the medical reports that there was that causal connect-  
3 ion, would the claim not then be allowed? Is it just  
4 a matter of establishing the tie between the two?

5 MR. HALL: As I understand it, a coronary  
6 condition, heart failure rather than right sided heart  
7 failure is not compensable as far as I know. I have had,  
8 I believe, two claims of this kind and this is the limit  
9 of my personal experience in this regard.

10 MR. GUTHRIE: Did you have something  
11 further to say, Mr. Kennedy?

12 MR. KENNEDY: No, nothing further.

13 MR. GUTHRIE: Then just one other thing:  
14 On page 15 of the brief I would like to be clear on  
15 just the form of amendment that you would recommend in  
16 that first paragraph. I assume you are speaking of  
17 the definition of industrial disease that should be  
18 amended, is that your point?

19 MR. KENNEDY: Yes.

20 MR. GUTHRIE: That is contained in  
21 Section 1, Sub-section (1) Clause (I). It means any  
22 of the diseases mentioned in Schedule 3 and any other  
23 disease peculiar to or characteristic of a particular  
24 industrial process, trade or occupation. Now, you say  
25 that you would recommend that the Act should be amended  
26 to provide compensation for diseases caused "Directly  
27 or indirectly by the nature of the employment".

28 MR. KENNEDY: That is correct. This,  
29 perhaps, gets to the nub of it.

30 MR. GUTHRIE: The definition of "Any







1 other disease peculiar to or characteristic of a  
2 particular industrial process, trade or occupation".  
3 Now, I think the drawback here is that if the liver is  
4 injured or the kidneys or some disease of the circulatory  
5 system/<sup>it</sup>may not be classed as peculiar to or characteristic  
6 of a particular industrial process, trade or occupation.  
7 So the real point is it could be indirectly?

8 MR. KENNEDY: That is right. When we  
9 have so much evidence of the rigorous, strict medical  
10 examinations, the annual medical examinations and x-rays  
11 of men who work in our industry, it would seem to me  
12 that if these develop in conjunction with silicosis,  
13 if there is any silicosis and any of these diseases  
14 develop, it should be compensable without any restrict-  
15 ions.

16 MR. GUTHRIE: I think I understand you.  
17 Thank you, Mr. Kennedy, that is all I have.

18 MR. KENNEDY: I want to thank you very  
19 much for your patience, Mr. Commissioner.

20 THE COMMISSIONER: Well, I see no reason  
21 why we shouldn't carry on. It is only ten to.

22 MR. GUTHRIE: Dr. Sutherland?

23 Dr. Sutherland, you have been called  
24 by the Commission today and I understand you have put  
25 your submission in the form of a written brief which  
26 you might like to furnish to the Commission. Perhaps  
27 as it deals with your background and qualifications,  
28 you might just like to proceed with the reading of that.

29 DR. SUTHERLAND: Mr. Commissioner, I  
30 have been requested by the Counsel for this Commission





1 to attend today's hearing to give evidence concerning  
2 silicosis and other chronic disabling lung conditions  
3 which may affect men employed in dusty trades, partic-  
4 ularly those which entail exposure to silica (i.e.,  
5 silicon dioxide) dust.

6 I am a duly qualified physician, a  
7 graduate of Queen's University in Kingston, on the  
8 register of the College of Physicians and Surgeons of  
9 Ontario. I hold the Diplomas in Public Health and in  
10 Industrial Hygiene granted by the University of Toronto.  
11 I am certified as a specialist in Occupational Medicine  
12 by the American Board of Preventive Medicine, and am a  
13 Fellow of the American College of Preventive Medicine.

14 For almost twenty years I have been  
15 employed in the Industrial Hygiene Branch of the Ontario  
16 Department of Health, and the the past two years have  
17 been Director of that Branch (Now called the Environ-  
18 mental Health Branch). I am an Associate Professor on  
19 the staff of the Department of Physiological Hygiene,  
20 School of Hygiene, University of Toronto. Since 1961  
21 I have served as Chairman of the Silicosis Referee  
22 Board of the Ontario Workmen's Compensation Board.

23 I have read the submissions of The  
24 Ontario Municipal Association, The Ontario Federation  
25 of Labour, The International Union of Mine, Mill &  
26 Smelter Workers, and The United Steelworkers of America  
27 which raise questions concerning silicosis and the more  
28 general problem of disability from chronic respiratory  
29 diseases, particularly emphysema and bronchitis, affect-  
30 ing men exposed to silica dust. The relationship of  
silicosis to lung cancer has also arisen in the





1 consideration of claims by the Workmen's Compensation  
2 Board, and I would ask your Honour's indulgence to  
3 speak to this subject as well.

4 It is necessary, first of all, to define  
5 and clarify certain terms. The word "pneumoconiosis"  
6 is usually defined as a condition or disease of the  
7 lungs caused by the inhalation of mineral or metallic  
8 dusts. In general, to reach the lung tissue proper,  
9 such dust particles must be less than 5 microns in  
10 diameter. (A micron is 1/1,000 of a millimeter, or  
11 1/25,000 of an inch). Larger particles rarely reach  
12 the lungs, but are trapped in the nose or mouth, or  
13 in the trachea or bronchi, and are later expelled.  
14 The reaction of the lung to particles reaching it  
15 varies, depending on the chemical or physical properties  
16 of the particles, their concentration in the inspired  
17 air, etc. Not usually included under the term pneumo-  
18 coniosis is the acute inflammatory reaction produced by  
19 certain metallic dusts such as cadmium oxide or the  
20 generalized systemic poisoning which may result from  
21 the inhalation of soluble toxic dusts such as lead  
22 oxide.

23 THE COMMISSIONER: I suppose, do we  
24 get cadmium oxide dust in Ontario in any operation?

25 DR. SUTHERLAND: We get it very, very  
26 seldom, sir.

27 THE COMMISSIONER: And what about lead  
28 oxide?

29 DR. SUTHERLAND: Lead oxide exposure is  
30 one of the most common in industry.







1 THE COMMISSIONER: Anywhere?

2 DR. SUTHERLAND: Anywhere. My point is  
3 that this is not known as pneumoconiosis.

4 THE COMMISSIONER: I know that is your  
5 point, I realize that.

6 MR. GUTHRIE: Would those two be included  
7 under the Item 7 in Schedule 3 which is simply "testing  
8 by (e) Cadmium and (k) Lead?"

9 DR. SUTHERLAND: They are covered in  
10 Schedule 3.

11 THE COMMISSIONER: Covered separately?

12 DR. SUTHERLAND: Yes.

13 THE COMMISSIONER: Thank you.

14 DR. SUTHERLAND: The majority of dusts  
15 are inert, in that they produce no acute inflammatory  
16 response or chronic fibrosis of the lungs. They may,  
17 because of their opacity to x-rays, give rise to  
18 shadowing in the chest film. Thus iron oxide deposited  
19 in the lung tissue produces a form of pneumoconiosis  
20 known as siderosis, characterized by a fine, stippled  
21 shadowing throughout both lungs in the chest roentgeno-  
22 graph. This condition is not disabling, and the stain-  
23 ing of the lungs by the iron oxide might be compared  
24 with the pigmentation of the skin produced by tatooing.

25 On occasion, respiratory disability may  
26 be produced by inert dusts, through a simple over-  
27 loading and plugging up of the air sacs with little or  
28 no accompanying fibrosis. Cases of such pneumoconiosis  
29 have resulted from the inhalation of talc and nepheline  
30 syenite. Both of these minerals are silicates, in which





1 the silicon is combined with one or more other elements  
2 such as calcium, magnesium or aluminium. Such cases  
3 of pneumoconiosis have occurred rarely, and only under  
4 extremely dusty working conditions.

5 THE COMMISSIONER: And I suppose they  
6 would be easily demonstrated and qualify for compensa-  
7 tion?

8 DR. SUTHERLAND: They will be accepted  
9 for compensation. I believe it is called a modified  
10 form of silicosis which I think was the phrase that was  
11 used.

12 THE COMMISSIONER: Now, perhaps, before  
13 we go on, we will adjourn until two o'clock, Doctor.

14  
15 --At 1:00 P.M., the Hearing adjourned until 2:00 P.M.  
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1 ---At 2:00 P.M., the Hearing re-commenced.

2  
3 THE COMMISSIONER: Yes, Doctor?

4 DR. SUTHERLAND: The more disabling forms  
5 of pneumoconiosis are caused by the inhalation of dusts  
6 which provoke a fibrotic response in the lungs, such as  
7 silica or asbestos. Silica, or silicon dioxide (fre-  
8 quently referred to as "free silica" to distinguish it  
9 from the silicates) occurs in nature in the pure form  
10 most commonly as quartz. It is the main constituent of  
11 sand, and is present in significant amounts in the  
12 native rock in the gold and uranium mining areas in  
13 this province.

14 When inhaled over a sufficient period of  
15 time, free silica may produce the disease known as  
16 silicosis, a condition characterized by multiple small  
17 fibrotic nodules scattered throughout both lungs. The  
18 nodules may be very small, less than 1 millimetre in  
19 diameter, or moderately large, up to 5 or 6 millimetres.  
20 Under the microscope they display a characteristic  
21 pattern or morphology. The degree of nodulation may  
22 vary from sparse to profuse. In his report of 1950,  
23 The Honourable Mr. Justice Roach summarized evidence  
24 presented by Dr. A. R. Riddell on the subject of  
25 silicosis. I would like to read into the record those  
26 paragraphs which in my opinion still apply today, and  
27 to comment on certain statements which for one reason  
28 or another should be modified or changed in the light  
29 of more recent knowledge:

30 "There is marked variation between







1 individuals in their susceptibility to  
2 the disease. Most people, even in quite  
3 marked exposure, are singularly resistant  
4 to it. On the other hand there are some  
5 persons who seem to be peculiarly suscept-  
6 ible to the disease.

7 "The industries in which the workers are  
8 subject to the disease are those in which  
9 the workers are likely to inhale excess-  
10 ive quantities of silica dust. They  
11 include mining, sand-blasting, porcelain  
12 making, rock grinding, stone cutting,  
13 moulding and grinding of materials which  
14 are grimy with sand."

15 By way of comment, to these industries  
16 might be added the manufacture and use of silica brick,  
17 as in the steel-making industry, the spraying of  
18 vitreous enamels, and the making of certain abrasive  
19 cleansers.

20 To quote again:

21 "The length of exposure sufficient to  
22 cause the disease in its compensable form  
23 varies also in the individuals. Taking  
24 the average worker in the various  
25 industries it would appear that miners  
26 and quarry workers may develop it in 13  
27 to 20 years; porcelain workers in certain  
28 occupations in 14 to 20 years; granite  
29 cutters in 27 to 29 years; moulders in  
30 28 to 30 years.





"A worker may develop a certain degree of silicosis, that is a certain amount of fibrous tissue in the lungs, and, notwithstanding continued exposure, the condition may remain stationary."

To this might be added the converse statement that progression of the condition may continue, even though the worker has been removed from exposure. Similarly, silicosis may first become apparent in the chest x-ray several years or more after the worker has left exposure.

Again I quote:

"The disease occurs in two forms. One is termed simple silicosis, that is the physical state which is marked only by a fibrotic condition of the lung tissue. The other is termed complicated silicosis, that is the physical state in which the fibrotic condition is complicated with infection, mainly tuberculosis of the lung.

"Simple silicosis may vary in extent from the stage where the number of nodules are few and small to the stage where large areas of the lungs are involved."

As the condition progresses, nodules which lie close together tend to fuse together, and thus larger areas of the lung tissue become fibrosed.

"Simple silicosis renders the lung tissue resistant to tuberculosis. Since tubercle





1                   culosis is caused by infection it is  
2                   imperative that a workman suffering from  
3                   simple silicosis should not be subjected  
4                   to the danger of such infection. Not  
5                   only is the silicotic susceptible to  
6                   tuberculosis but the tuberculant is  
7                   susceptible to silicosis. Therefore,  
8                   a person who has tuberculosis or has had  
9                   it but been cured should never be exposed  
10                  to the inhalation of silica dust."

11                 In my opinion, the last statement should  
12                 be clarified. It is correct if the reference to tuber-  
13                 culosis is interpreted as meaning active tuberculous  
14                 disease or arrested pulmonary tuberculosis which has  
15                 left evidence of scarring of the lungs. There is ample  
16                 evidence, both experimental and human, to indicate that  
17                 such persons are poor risks for work in silica exposure.  
18                 On the other hand, I know of no valid evidence to  
19                 indicate that a person is a poor risk for silica exposure  
20                 who has a clear chest film and has only a positive  
21                 tuberculin test to show that he has had a previous  
22                 infection with the tubercle bacillus.

23                 THE COMMISSIONER: There was a time when  
24                 the medical profession had TB at one time or another?

25                 DR. SUTHERLAND: In the older age  
26                 groups the majority of them still had positive tubercular  
27                 reactions, particularly immigrants from Europe.

28                 During the years prior to 1950, tuberculosis  
29                 as stated by Dr. Riddell in the sentence which followed  
30                 the above quotation, accounted for 60 to 70 percent of







1 the deaths among silicotics. At that time pneumonia  
2 and right heart failure, both of which might be con-  
3 sidered complications of silicosis, were responsible  
4 for a further 10 to 15 percent of deaths in silicotics.

5 That would amount to something like  
6 almost 90 percent of deaths among silicotics that were  
7 due to tuberculosis, pneumonia or right heart failure.  
8 at the time that Dr. Riddell was speaking in 1950.

9 With the advent of chemotherapy for  
10 tuberculosis, this picture has changed radically.

11 THE COMMISSIONER: You refer there again,  
12 as Mr. Kennedy did, to right heart failure. What is  
13 the distinction there that would make it compensable?

14 DR. SUTHERLAND: The heart consists of  
15 four chambers. It is really, shall we say, a double  
16 pump, a pump on the right and a pump on the left. The  
17 pump on the right is concerned with pushing the blood  
18 through to the lungs and on its return it enters the  
19 left side of the heart and is circulated through the  
20 body. So, a condition of fibrosis or anything to  
21 cause obstruction to the flow of blood to the lungs  
22 would cause a back pressure on the right side of the  
23 heart.

24 THE COMMISSIONER: It would have to occur  
25 on the way into the lungs and not on the way out?

26 DR. SUTHERLAND: This is true, pressure  
27 back from the lungs to the right side of the heart.  
28 This throws a strain on that side of the heart.

29 THE COMMISSIONER: I understand.

30 DR. SUTHERLAND: During the period 1960  
to 1964, tuberculosis was responsible for only about 8





1 percent of the deaths in silicotics, with pneumonia  
2 accounting for approximately 20 percent and right heart  
3 failure for about 24 percent. Nearly 48 percent of  
4 silicotics now die of conditions unrelated to their  
5 silicosis, such as coronary artery disease, cancer,  
6 cerebral haemorrhage, cancer, accidents, etc. This  
7 changing mortality picture has undoubtedly resulted in  
8 the rejection of a relatively higher proportion of  
9 claims for death benefits and pension benefits to  
10 widows and dependents, and has almost certainly generated  
11 feelings of dissatisfaction over the settlement of  
12 specific claims. Such feelings are understandable, and  
13 I have every sympathy for the widow so deprived of a  
14 pension. However, such settlements must be based on  
15 whether there is medical evidence or expert opinion  
16 relating the cause of death to the occupational disease  
17 from which the worker suffered. If there is none, then  
18 the allowance of benefits, in my opinion, would con-  
19 stitute a misuse of compensation funds for purely social  
20 or welfare purposes.

21 It is perhaps appropriate here to con-  
22 sider the question of lung cancer occurring in a  
23 silicotic. In the majority of such cases, the lung  
24 cancer will probably be the eventual primary cause of  
25 death. The basic question is, "Did the silicosis cause  
26 the lung cancer to develop?"

27 Lung cancer presently accounts for some  
28 6 percent of deaths in males over the age of 60 years  
29 in Ontario, regardless of what occupations they have  
30 worked in all of their lives. Since 1961 there have





1 been 355 deaths from all causes among silicotics in  
2 Ontario, of which 21 were due to lung cancer. Dr.  
3 A.H. Sellers, former Director of the Medical Statistics  
4 Branch, Ontario Department of Health, has computed the  
5 number of lung cancers which would normally have been  
6 expected among these 355 silicotics if they had sustained  
7 the same proportion of lung cancer deaths in each age  
8 group as occurred in Ontario males. The number expected  
9 was estimated at 16, compared with the 21 cases which  
10 occurred. While this represents an increase of some  
11 30 percent over the number normally expected, the  
12 increase is not statistically significant. To express  
13 it crudely, there was about a fifty-fifty chance, when  
14 16 cases were normally expected, of having as many as  
15 21 cases occur.

16 An increase of 30 percent over the  
17 normal lung cancer expectancy in this group of men  
18 may be compared with the findings in other studies of  
19 lung cancer in relation to occupation. In five such  
20 studies which I have either carried out or assisted in,  
21 it was found that the risk of lung cancer was roughly  
22 5 to 7 times normal in certain specific occupations.  
23 Increases of this magnitude would occur by chance less  
24 than 1 in 100 or 1 in 1,000 times. As a result of  
25 these investigations it was considered that the increased  
26 risk of lung cancer was related to occupational exposure,  
27 and in the three studies done in Ontario lung cancer  
28 was accepted as a compensable condition when occurring  
29 in the specified occupations and action was taken to  
30 eliminate the hazard at the workplaces.







1                   Increases of the same order of magnitude  
2 have been reported for lung cancer in at least two  
3 industrial studies performed in the United States, two  
4 in Great Britain, two in Europe, and one in Japan. In  
5 none of the studies mentioned was exposure to silica  
6 considered to be related to the increase. In several  
7 of the studies where mining was involved, radio-active  
8 gasses and dusts were also present in the atmosphere in  
9 high concentrations, and the increase in lung cancer  
10 was considered to be associated with this exposure.

11                   In South Africa, where there has been  
12 longer experience with silicosis than we have had in  
13 Ontario, no increase in the incidence of lung cancer  
14 has been found, over what might normally have been  
15 expected. From the experimental side, it might be  
16 noted that no cases of lung cancer have been reported in  
17 the thousands of animals which have been used over the  
18 past forty or fifty years in studies of silicosis.

19                   It is therefore my considered opinion  
20 that there is no evidence to indicate that silicosis or  
21 exposure to silica dust results in an increased risk of  
22 developing lung cancer. This should not be taken to  
23 imply that the subject is closed. The experience of  
24 our miners, and of our silicotics in particular, is  
25 under continuing review.

26                   The foregoing conclusion concerning the  
27 relationship between silicosis and lung cancer is in  
28 contrast to the known experience in cases of asbestos  
29 fibrosis of the lungs. Various studies have shown that  
30 lung cancer has been responsible for from 15 to 23





1 percent of all deaths occurring in men with asbestosis.  
2 Investigations are under way to determine whether the  
3 increased risk of lung cancer is associated with all  
4 kinds of asbestos, or restricted to fibres of a certain  
5 type. Lung cancer has been accepted as a compensable  
6 condition in the few cases of asbestosis in Ontario  
7 in which it has developed.

8 Chronic bronchitis is a clinical disorder  
9 characterized by excessive mucus secretion in the  
10 bronchial tree, accompanied by chronic or recurrent  
11 cough. The condition is most prevalent among males  
12 over 35 years of age, and occurs predominantly, but  
13 not exclusively, in cigarette smokers. There are no  
14 characteristic abnormalities seen in the chest x-ray  
15 film. Any alterations of respiratory function consist  
16 primarily of increased resistance to air flow.

17 Emphysema is an anatomic alteration of  
18 the lung characterized by an abnormal enlargement of  
19 the air spaces distal to the terminal bronchioles and  
20 accompanied by destructive changes in the alveolar  
21 walls.

22 THE COMMISSIONER: The first one is  
23 chronic bronchitis which is a clinical disorder?

24 DR. SUTHERLAND: Clinical condition, yes.

25 THE COMMISSIONER: You say there are no  
26 characteristic abnormalities in the x-ray. In other  
27 words, it is just sort of an inflammation of the  
28 bronchial tubes, is that it?

29 DR. SUTHERLAND: Right, characterized by  
30 chronic cough and collection of mucus.





1 THE COMMISSIONER: Then emphysema is  
2 enlarged air spaces distal to the bronchioles. Where  
3 is that, at the end of the passages?

4 DR. SUTHERLAND: The very next sentence  
5 here is to put this rather in lay terms - there is over-  
6 distension and destruction of the walls of the small air  
7 sacs at the end of the bronchial tree.

8 THE COMMISSIONER: I see, all right.  
9 Over-distension and destruction of the walls of the small  
10 air sacs at the end of the bronchial tree. I think I  
11 understand it now. That is what you call alveolar walls?

12 DR. SUTHERLAND: The alveolar are small  
13 air sacs, yes.

14 THE COMMISSIONER: Perhaps you can tell  
15 me what the emphysema are - perhaps you can tell me  
16 what that word is.

17 DR. SUTHERLAND: Which word is that?

18 THE COMMISSIONER: Well, go on reading.

19 DR. SUTHERLAND: The tissue changes may  
20 vary in their distribution and extent. Thus the  
21 emphysema may be paracicatricial. A cicatrix is a scar  
22 so that means that the emphysema area may lay adjacent  
23 to scar tissue, a fibrosis, in other words.

24 An over-distension of the air spaces and  
25 a destruction of the alveolar wall in those areas of  
26 lung adjacent to fibrotic lesions of the lung.

27 THE COMMISSIONER: Fibrotic lesions in  
28 the lung are silicosis?

29 DR. SUTHERLAND: This is one form of  
30 fibrosis, but it could also result from tuberculosis or







1 other inflammation - scarring is a simpler word for it.

2 THE COMMISSIONER: It could be adjacent  
3 to, you say?

4 DR. SUTHERLAND: This is correct.

5 THE COMMISSIONER: All right.

6 DR. SUTHERLAND: In lobular emphysema --

7 THE COMMISSIONER: Wasn't that lobular  
8 emphysema you were talking about?

9 DR. SUTHERLAND: No, that <sup>was</sup> paracicatricial.

10 I am sorry it is necessary to say this, but you cannot  
11 talk about emphysema unless you mention the various  
12 types.

13 In lobular emphysema, the over-distension  
14 and destruction of the walls of the air sacs occurs in  
15 anatomic segments of the lung known as secondary lobules.  
16 This form of emphysema is not associated with fibrotic  
17 lesions.

18 THE COMMISSIONER: Now I am in trouble,  
19 because I don't know enough about the anatomy of the  
20 lungs. Your first part is in connection with the  
21 destruction of the walls of the small air sacs at the  
22 end of the bronchial tree. Now, somewhere along the  
23 bronchial tree, there are these lobes you are talking  
24 about?

25 DR. SUTHERLAND: It is like the last few  
26 sprigs on a small branch. There is a group which con-  
27 stitutes the alveolar.

28 THE COMMISSIONER: The biggest ones from  
29 which the smallest ones run off?

30 DR. SUTHERLAND: You have the trachea





1 bronchias, the respiratory bronchials and then the  
2 air sacs or aveolo. So the lobule itself is really  
3 a certain segment of the lung which consists of all  
4 the bifurcations on the end of this one small bronchial  
5 and then the other lobules which are really a supply  
6 to the others.

7 THE COMMISSIONER: I think I understand.

8 DR. SUTHERLAND: This form of emphysema  
9 basically is not associated with fibrotic lesions. It  
10 may involve one or more lobes of the lungs, or may be  
11 generalized, affecting all areas of both lungs. There  
12 are three lobes in the left lung and two lobes in the  
13 right.

14 THE COMMISSIONER: Why wouldn't that  
15 be associated as the other ones? The other one could  
16 just be alongside of some fibrosis. Can't you have  
17 fibrosis in the lobules?

18 DR. SUTHERLAND: The reason that this  
19 distinction is important here is that where one has  
20 scarring, one usually has retraction of the scar tissue,  
21 it shrinks. Since it is shrinking away and you can't  
22 leave a vacuum it tends to pull and distort  
23 the surrounding tissue causing it to become emphysemous.  
24 This is the paracicatricial type.

25 The lobule is not associated with  
26 fibrosis at all. This is a condition which does develop  
27 not as a result of scarring of the lungs at all.

28 THE COMMISSIONER: What you are trying  
29 to say now is that of these two, one of them might be  
30 due to silicosis?





1 DR. SUTHERLAND: I make the point later  
2 on that the paracicatricial is a recognized development  
3 where massive fibrosis occurs in cases of silicosis and  
4 it is accepted as such.

5 THE COMMISSIONER: All right.

6 DR. SUTHERLAND: With the lobular emphysema  
7 obstruction of air flow is a common feature, and, of  
8 course, it is this obstruction of air flow which is  
9 responsible for much of the disability which one  
10 complains of if one has emphysema.

11 Closely allied to lobular emphysema is  
12 the focal emphysema first described by Gough in men  
#2 13 with coal-workers' pneumoconiosis in Great Britain.

14 THE COMMISSIONER: When you are demonstra-  
15 ting on an x-ray, how do you know whether it is lobular  
16 or otherwise?

17 DR. SUTHERLAND: It can only be demon-  
18 strated pathologically, a pathological section using  
19 large thin slices. You cannot see these distinctions  
20 in a chest x-ray.

21 THE COMMISSIONER: You are able to get such  
22 pathological specimens?

23 DR. SUTHERLAND: We have a large number  
24 of such specimens on our silicotics.

25 THE COMMISSIONER: Are you able to get  
26 them from a living person?

27 DR. SUTHERLAND: No. The best one could  
28 hope to do would be to do a lung biopsy and  
29 take out a small segment in a living person.

30 THE COMMISSIONER: I just wondered how







1 you diagnosed whether it is one form or the other.

2 DR. SUTHERLAND: It is not easy. In fact  
3 it is extremely difficult in a lot of cases until a  
4 person is deceased to know just exactly what form it  
5 was.

6 Closely allied to lobular emphysema is  
7 the focal emphysema first described by Gough in men with  
8 coal-workers' pneumoconiosis in Great Britain. In this  
9 condition there is dilatation and distension of the  
10 air spaces in the lobules, but destruction of the  
11 alveolar walls is not a feature nor is obstruction to  
12 the respiratory air flow common. According to Gough,  
13 focal emphysema characteristically develops in men  
14 exposed to coal dust. It may also develop following  
15 inhalation of natural graphite and pure carbon dusts.  
16 It is not known to be caused by silica dust.

17 Another form of emphysema, known as  
18 generalized vesicular emphysema, involves the lung as  
19 a whole rather than affecting the lobules individually.  
20 In this form of emphysema there is relatively uniform  
21 enlargement of the air spaces diffusely throughout both  
22 lungs, but little destruction of the walls of the air  
23 sacs unless the condition is severe.

24 THE COMMISSIONER: Do you have the same  
25 kind of symptoms in the third case as in the others,  
26 I mean to say, are they debilitated?

27 DR. SUTHERLAND: I will come to the  
28 symptoms in a moment.

29 Clinically, some persons with emphysema  
30 have no symptoms or abnormal physical signs, and the  
chest film may be normal even though emphysema is found





1 on pathological examination of the lungs. Where the  
2 disease is more marked patients will usually complain  
3 of shortness of breath on exertion. This is much the  
4 same complaint as with silicosis. And when severe,  
5 they may complain of air hunger even at rest. The  
6 diagnosis is usually made clinically and by pulmonary  
7 function studies, the chest x-ray providing confirmatory  
8 evidence. When evidence at all is present, it is only  
9 confirmatory. Emphysema usually occurs in men over  
10 40 years of age who have a long history of chronic  
11 bronchitis and cigarette smoking. In advanced cases,  
12 the disease is totally disabling.

13 In Great Britain, for many decades,  
14 chronic bronchitis has been a major cause of incapacity  
15 for work, and the disease has been the subject of many  
16 studies. In the United States and Canada, mortality  
17 data are available only for the years since 1950,  
18 approximately. In both countries the crude death rate  
19 from emphysema, with or without mention of chronic  
20 bronchitis, has risen faster than other causes of death,  
21 including lung cancer, during the past fifteen years.  
22 More complete studies in the United States have demon-  
23 strated that the death rate for emphysema in white  
24 males rose more than 6 times from 1949 to 1959. A recent  
25 survey by Dr. A. H. Sellers of Ontario mortality during  
26 the years 1951 to 1963 has revealed that the greatest  
27 increase in emphysema has occurred in men over the age  
28 of 55 years. Among men aged 55 to 64 the death rate  
29 tripled; among those aged 65 to 74 the increase was  
30 nearly fourfold; and in men aged 75 and over the increase





1 was more than 8 times.

2 It is evident that with an increasing  
3 incidence of emphysema --

4 THE COMMISSIONER: What is the difference  
5 between bronchitis and asthma, can you tell me that?

6 DR. SUTHERLAND: Asthma is really an  
7 allergic condition. The individual is sensitive --

8 THE COMMISSIONER: Yes, but it would  
9 not be included in these figures, it would not be con-  
10 sidered as a bronchitis?

11 DR. SUTHERLAND: It is not included in  
12 these figures, it is a different condition.

13 THE COMMISSIONER: Then, when a person  
14 dies of bronchitis, would that be pneumonia that he  
15 would have?

16 DR. SUTHERLAND: No, it is probable  
17 that he has actually developed emphysema and he has  
18 died of the combined conditions.

19 THE COMMISSIONER: Shortness of breath?

20 DR. SUTHERLAND: He would have acute  
21 shortness of breath and if he died of this condition,  
22 loss of sufficient respiratory tissue that he could  
23 no longer get enough oxygen into his body to sustain  
24 life.

25 THE COMMISSIONER: The reason I asked  
26 was I didn't know people died of bronchitis.

27 DR. SUTHERLAND: It is usually emphysema.

28 THE COMMISSIONER: Oh, I see, and you  
29 are talking about another thing in bronchitis?

30 DR. SUTHERLAND: You can't really







1 separate the two, Mr. Commissioner. The bronchitic  
2 side of this thing is predominant in Great Britain and  
3 for many decades it was sort of regarded as the English  
4 disease or some such title. This dates back to the turn  
5 of the Century. On this continent we don't have nearly  
6 as much, didn't used to have as much bronchitis. The  
7 respiratory disability was probably more predominantly  
8 emphysema, with a lesser bronchitic element attached  
9 to it.

10 THE COMMISSIONER: Well, Dr. Sellers'  
11 studies refer to emphysema, he is not talking about  
12 bronchitis in particular?

13 DR. SUTHERLAND: Essentially, it is  
14 emphysema and there may or may not have been a mention  
15 on the death certificate<sup>of</sup> the words "Chronic Bronchitis",  
16 but, essentially, these are cases of emphysema.

17 It is evident that with an increasing  
18 incidence of emphysema in the older male age groups  
19 generally, more and more workers in dusty trades will  
20 also develop the condition. The question before us is  
21 whether exposure to dust over many years will result in  
22 an even greater increase in the disease in these  
23 workers.

24 The cause of emphysema has been the  
25 subject of considerable research particularly in the  
26 past decade. With reference to the lobular and  
27 generalized vesicular forms of the disease, the general  
28 consensus of reports to date is that cigarette smoking  
29 is a major factor in their development, and that air  
30 pollution also plays a part, though a lesser one. Focal





1 emphysema is a recognized result of the inhalation of  
2 carbonaceous dusts.

3 Advanced cases of simple silicosis may  
4 occur without any evidence of emphysema. However,  
5 emphysema can occur around silicotic nodules, though  
6 with less frequency than in coalminers' pneumoconiosis.

7 THE COMMISSIONER: What is focal emphysema?

8 DR. SUTHERLAND: Focal emphysema is  
9 simply a dilation of the air sacs which are immediately  
10 surrounding deposits of coal dust. There is really not  
11 much destruction of the air sacs by this form of emphysema  
12 or affect on breathing. In cases of silicosis wherein  
13 there has been formation of large fibrous masses,  
14 localized areas of paracicatricial emphysema frequently  
15 develop. In such cases, the emphysema is recognized as  
16 an integral part of the silicotic process, and insofar  
17 as the emphysema increases the patient's disability it  
18 is considered compensable.

19 There is as yet no valid evidence to  
20 show that the common forms of emphysema, the lobular  
21 and the generalized vesicular forms, occur with greater  
22 than normal frequency in men exposed to silica. This  
23 subject also, however, is under continuing study, in  
24 this country and in others.

25 I had one other point I wanted to discuss  
26 which may bear on the causes.

27 THE COMMISSIONER: I think we will just  
28 let this sink in. In other words, you say there are a  
29 number of types of emphysema, two types anyway, which  
30 are not related, there is no present indication that





1 there is an undue incidence of them among people exposed  
2 to silica dust.

3 DR. SUTHERLAND: That is correct.

4 THE COMMISSIONER: The third type may be  
5 traced to that and it would come under number 8 in  
6 Schedule 3?

7 DR. SUTHERLAND: We simply considered it  
8 an integral part of silicosis, totally disabled because  
9 of emphysema or tuberculosis.

10 THE COMMISSIONER: If silicosis were  
11 present and you can verify yourself that it was type 1,  
12 then it would become compensable?

13 DR. SUTHERLAND: I don't think the  
14 Board is going to try to distinguish between the two.  
15 They would have to give the man the benefit of the doubt  
16 that the emphysema which he had was related to silicosis.

17 THE COMMISSIONER: So that would refer  
18 to cases which developed subsequent to a silicosis  
19 condition?

20 DR. SUTHERLAND: Yes.

21 THE COMMISSIONER: Mr. Kennedy has  
22 referred to other cases which occur prior to a silicosis  
23 condition and, as you say, there is no indication that  
24 exposure to silica dust has indicated any major increase  
25 in the incidence in those cases?

26 DR. SUTHERLAND: In our examinations of  
27 claimants which are conducted in the north country and  
28 here in Toronto we see, I guess almost any miner who  
29 has worked under silica exposure for two years or more  
30 will claim disability. It is possible that he has been







1 exposed to silica and, in fact, be a respiratory cripple  
2 without any evidence of silicosis in the chest film of  
3 silicotic nodulation. The point, then, I think, is do  
4 such cases of emphysema or pulmonary disease, not silicotic,  
5 occur with greater frequency than they do in the normal  
6 population? I don't know of any evidence at all which  
7 suggests that men exposed to silica are more prone to  
8 develop this kind of emphysema. As I say, the subject  
9 is under continuous study. It could be that this is the  
10 reason these cases crop up more frequently and are simply  
11 an indication of the general increase of emphysema which  
12 has occurred in the last 15 years that we know of. We  
13 can't go back any further because we don't have records  
14 to go back into the 1940's.

15 There are other dust trades where emphysema  
16 has been recognized in men working with cadmium oxide.  
17 It has been recognized in a recent report as a complication  
18 of inhalation of that particular dust.

19 THE COMMISSIONER: That is one you mentioned  
20 in connection with cancer?

21 DR. SUTHERLAND: No, acute pulmonary  
22 oedema. I didn't mention any specific case in connection  
23 with cancer.

24 I wonder, perhaps, if I might interpose  
25 some remarks here which really deal with the subjects  
26 raised by Mr. Kennedy earlier this morning, because he  
27 was dealing right in this area. The other topic I  
28 wanted to deal with doesn't deal with these things. Mr.  
29 Kennedy stated there are many new gases and fumes being  
30 introduced as a result of new chemical processes each





1 year, and this is true. I think, perhaps, one point  
2 might be made here. Certainly new chemicals are  
3 developed by the larger companies. This true, partic-  
4 ularly in the United States. Most of these chemicals  
5 are subjected to toxicity testing before they are  
6 allowed in Canada. In fact, some are not on the market  
7 because there has been no safe way of handling them.  
8 Those that are allowed on the market, usually protective  
9 measures are specified when they are going to be used.  
10 Even in spite of this it is true that workers may  
11 suffer from the effects of these new materials. An  
12 example of this is the introduction of tolyene di-  
13 isocyanate, commonly known as TDI. We have had cases  
14 of toxic asthma being formed in men as a result of this  
15 exposure.

16           Regarding the work of Dr. Schepers, I  
17 think I should make a comment here. I am familiar with  
18 the literature here and I know Dr. Schepers slightly..  
19 I am not familiar with his laboratory or what was done  
20 particularly, but I would like to make one or two  
21 pertinent remarks. The work reported by Mr. Kennedy  
22 was essentially on rats, but to some extent guinea pigs  
23 were used. I think it is also significant that the  
24 dose was administered to these animals by injection  
25 down their windpipes. This is not inhalation; it is  
26 an artificial method of introducing it into their lungs.  
27 You are injecting it on one or two or three discreet  
28 occasions. 50 to 150 milligrams were used. This is  
29 quite a large dose which swamps the lung. In doing  
30 this kind of experiment there is a tendency, I think,





1 to have considerable reaction on the tissue. It is a  
2 useful kind of experiment to lead the way into more  
3 refined experiments. If, by doing this, you get a  
4 certain kind of reaction, then you usually go to an  
5 inhalation experiment and have them inhale to see whether  
6 the animals will develop conditions similar to those  
7 that humans have already suffered, or this may be done  
8 in advance to protect humans to derive protective  
9 measures so that they will not be exposed if the material  
10 turns out to be toxic.

11 THE COMMISSIONER: We made some effort  
12 to get in touch with Dr. Schepers and we finally found  
13 he was stationed in California and we gave it up.

14 DR. SUTHERLAND: Most of his reports do  
15 mention emphysema. If one reads his reports, you  
16 usually find that what he has done is minimal. Our  
17 scientists for years have been looking for a way to  
18 introduce emphysema so that they could study this  
19 disease. Despite what Dr. Schepers has done since 1955,  
20 this is not the kind of emphysema we are speaking of  
21 in the general population, the nodular type of  
22 emphysema, and so on. It is only in the last two or  
23 three years that scientists have been able to introduce  
24 emphysema essentially into the lungs, and two particular  
25 gases were used, oxide of nitrogen and phosgene gas.

26 I would like to comment on the relation-  
27 ship of silicosis to the heart, liver and kidneys. You  
28 have already asked one question concerning right heart  
29 failure. These were the three organs mentioned in Mr.  
30 Kennedy's remarks this morning. He quoted, I believe,







1 Dr. Schepers as the source of the statement. I am not  
2 familiar with Dr. Sappington. Schepers I knew. He  
3 wasn't particularly <sup>a</sup>pneumoconiosis expert; he was an  
4 expert on occupational diseases generally, but his field  
5 was not pneumoconiosis. I can understand the statement  
6 that <sup>the</sup>/liver might be affected, but the only way I might  
7 see it affected would be terminal, where a patient had  
8 severe, prolonged right heart failure, where a further  
9 shifting can affect the liver so that the liver suffers  
10 congestion and enlargement. I might say that this is  
11 a terminal condition in a silicotic who has severe right  
12 heart failure. I have read no reports at all where  
13 kidneys have been shown to be affected by silicosis.  
14 The only experimental work along this line is quite  
15 artificial in relation to human exposure. If one injects  
16 silica into the blood stream of an animal it will  
17 develop silicosis in various organs, including the liver,  
18 the spleen, as well as the lungs, but by inhalation there  
19 is no way for the silica to get out of the lungs, so  
20 you do not get nodulation occurring in the liver, the  
21 spleen or the heart.

22 In relation to coronary heart disease,  
23 this affects the coronary vessel wall, and it happens  
24 that <sup>the</sup>/coronary artery is the terminal artery, which  
25 means that if it gets blocked there is no further blood  
26 supply to the heart muscle and the heart muscle will go  
27 into a cramp and it will stop beating. If there was a  
28 collateral supply coming in, then a blockage wouldn't  
29 particularly affect it, so that perhaps coronary diseases  
30 wouldn't be so particularly fatal.





1 THE COMMISSIONER: I understood you to  
2 say earlier that it might be due to the added load on  
3 the heart seeking to pump blood to organs which were not  
4 functioning efficiently.

5 DR. SUTHERLAND: The right side of the  
6 heart, yes. This is quite a different thing from  
7 coronary artery disease.

8 THE COMMISSIONER: You are talking about  
9 something else. You are talking about coronary artery  
10 disease?

11 DR. SUTHERLAND: Yes. Coronary artery  
12 disease is, shall we say, one aspect of generalized  
13 arterio-sclerosis, which is a thickening of the blood  
14 vessels pretty well throughout the body. When the  
15 coronary artery itself is blocked, I think one of the  
16 reasons it becomes an acute problem is that it is a  
17 terminal artery. I know of no statistics at all that  
18 silicosis might have produced arterio-sclerosis.

19 THE COMMISSIONER: Where there is pressure  
20 on the heart to push silicosis through the lungs, what  
21 happens then?

22 DR. SUTHERLAND: You mean acute heart  
23 failure?

24 THE COMMISSIONER: I am talking about  
25 heart failure on the right side which follows when there  
26 is silicosis.

27 DR. SUTHERLAND: The heart muscle, partic-  
28 ularly on the right side, attempts, first of all, to  
29 strengthen itself and becomes thicker. It is the  
30 resistance to the passage of blood in the lungs that is





1 increased , the pressure builds up, the heart will start  
2 to dilate. This makes the valves in the heart inefficient,  
3 and back pressure will also lead to congestion. It may  
4 very well lead to congestion of the liver. There will  
5 be a build up of toxic products in the body and it  
6 eventually will stop working.

7 Then, may I go back to the last subject  
8 I wanted to discuss. I would like to draw to the  
9 attention of this Commission the way in which claims for  
10 silicosis are processed since it is quite different from  
11 the manner in which claims for other industrial diseases  
12 are handled. Provided that the silicosis claimant can  
13 show that he has had two years of silica exposure in  
14 Ontario, and that he has not subsequently sustained  
15 two years or more of silica exposure elsewhere, he will  
16 be referred to the Silicosis Referee Board for examina-  
17 tion prior to consideration of his claim. The Referee  
18 Board is asked to give its opinion as to whether or not  
19 silicosis is present and to assess the degree of disabili-  
20 ty therefrom. In other words, the claimant is examined  
21 by impartial referees who have been selected as experts  
22 in the field of silicosis, before the initial decision  
23 is given on a claim. This is quite the reverse of the  
24 procedure followed with other industrial injuries. Before  
25 rendering its opinion, the Silicosis Referee Board  
26 recognizes that it must have as much information as  
27 it is possible to obtain on the case. Not infrequently,  
28 in difficult cases the Referee Board will ask for special  
29 investigation in hospital or sanatorium before rendering  
30 its opinion. The Referee Board also stands ready to







1 reconsider its opinion at any time in the light of new  
2 medical information. Once seen by the Referee Board,  
3 the individual case is customarily followed, at intervals  
4 ranging from 6 months to two or three years, so that  
5 further developments, such as increasing disability,  
6 can be assessed.

7 It is therefore respectfully suggested  
8 to this Commission that the medical opinions of the  
9 Silicosis Referee Board should not be subject to reversal  
10 by decisions of the Review Committee, the Appeal Tribunal  
11 or the Compensation Board itself, particularly when no  
12 new medical evidence is submitted at these hearings.

13 THE COMMISSIONER: Who appoints the  
14 Silicosis Referee Board? Who appoints you? You are  
15 on it, are you?

16 DR. SUTHERLAND: I am. The Board was  
17 still  
18 originally appointed, and / is appointed, by mutual  
19 agreement between the Minister of Health and the Chair-  
20 man, I believe, of The Compensation Board. I don't  
21 believe the Minister of Labour gets involved in it, but  
22 I wouldn't be sure about that.

23 MR. GUTHRIE: Is it recognized in The  
24 Workmen's Compensation Act? I can't find a reference  
25 to it.

26 DR. SUTHERLAND: I don't believe it is.

27 THE COMMISSIONER: Who else is on that  
28 Board?

29 DR. SUTHERLAND: Dr. Rorabeck, C.H.  
30 Rorabeck. He is a Director of Tuberculosis Prevention  
in the Department of Health. Dr. J. E. Powell, who is a



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1 clinician in the Environmental Health Branch.

2 THE COMMISSIONER: So there are three of  
3 you?

4 DR. SUTHERLAND: In addition, Dr. A.R.  
5 Riddell, who was a member of the original Board from  
6 1928 and who still acts as a consultant to the Referee  
7 Board. He attends all our meetings. So, really, there  
8 four.

9 THE COMMISSIONER: In other words, as  
10 far as the personnel of the Board is concerned, The  
11 Workmen's Compensation Board has nothing to do with  
12 its appointment ?

13 DR. SUTHERLAND: The Workmen's Compensa-  
14 tion Board agreed to the establishment and agreed to  
15 the individual appointments.

16 THE COMMISSIONER: It is the Minister of  
17 Health really?

18 DR. SUTHERLAND: Actually, in the history  
19 of this thing, the Board which was originally selected  
20 was selected as the Director of the Hygiene Branch  
21 on the basis that he would know most of the working  
22 conditions underground, and the Director of the Tuber-  
23 culosis Prevention Branch, because tuberculosis, as  
24 such, is a large factor in silicosis, and the  
25 third is a specialist. Now, these people were agreed  
26 upon by the Department of Mines, and The Workmen's  
27 Compensation Board, the Mining Association, and I  
28 suppose in those days there were no labour unions to  
29 agree or object, but the idea was to set up an impartial  
30 group to give an independent and impartial opinion.





1 THE COMMISSIONER: Now, you obviously  
2 deal with silicosis cases. Do you deal with emphysema  
3 cases?

4 DR. SUTHERLAND: Only insofar as they  
5 would be referred as a person who has been under dust  
6 exposure.

7 THE COMMISSIONER: If he said that this  
8 was one of the cases of silica exposure, would they  
9 come to you?

10 DR. SUTHERLAND: Yes.

11 THE COMMISSIONER: You say your present  
12 suggestion is that there should be no appeal from the  
13 decision of your impartial tribunal?

14 DR. SUTHERLAND: May I continue with  
15 what I have written here?

16 THE COMMISSIONER: Yes.

17 DR. SUTHERLAND: If such evidence is  
18 forthcoming, the case should be referred back to the  
19 Silicosis Referee Board for reconsideration. It is,  
20 of course, quite proper that the appeal framework  
21 should review the decisions of the Referee Board to  
22 ensure that that body has, in fact, obtained and  
23 reviewed all pertinent information available in a case  
24 before it renders its opinion. To ensure both manage-  
25 ment and labour that fair, impartial and expert con-  
26 sideration was given to each case, thought might be  
27 given to having a physician designated by each side  
28 attend Referee Board meetings as observers.

29 The basic point is that the diagnosis of  
30 an occupational disease such as silicosis, the assessment







1 of physical disability, the relationship of the disease  
2 to other conditions which may develop concurrently, are  
3 all matters to be decided essentially on medical grounds,  
4 rather than legalistically.

5 THE COMMISSIONER: There doesn't really  
6 seem to be much point if your Board were given the final  
7 say and having it then go to a court of appeal and then  
8 go to the tribunal?

9 DR. SUTHERLAND: I am trying to - at  
10 least I would like to indicate that anything I say is  
11 personal. This is presented with my background and  
12 experience. But whether I am a member of the Referee  
13 Board or not, is quite beside the point. If one is  
14 going to handle silicosis claims by referring them to  
15 experts to get their opinion, then this is my whole  
16 point, sir. The procedure is quite reversed here.

17 THE COMMISSIONER: What if your experts  
18 don't agree?

19 DR. SUTHERLAND: They keep hammering at  
20 it until they agree. If there is disagreement, you can  
21 rest assured that the case will be reviewed again in  
22 a very short time and any help given to assist in arriv-  
23 ing at a proper decision. If a claim is not allowed,  
24 but there is some doubt in our minds, that person will  
25 be seen again, probably in six months, certainly in a  
26 year.

27 THE COMMISSIONER: Do you know of any  
28 cases in which your opinion hasn't been accepted by the  
29 Board in these appeals?

30 DR. SUTHERLAND: I only know of two or





1 three.

2 THE COMMISSIONER: At the moment, the  
3 workman has an absolute right to appeal within the  
4 structure of the Board. At least, if it is not absolute,  
5 it should be absolute. But he is given a right of appeal.  
6 If your suggestion were carried out, he has a right of  
7 appeal except in these cases. He has no right of appeal  
8 once your silicosis committee has decided it. It would  
9 be easier, unless there was some abuse of the process  
10 and you were being consistently overruled, to leave it  
11 the way it is?

12 DR. SUTHERLAND: I don't mean that the  
13 right of appeal doesn't exist and the procedure may  
14 still continue, but it is the grounds on which appeals  
15 are being reversed that concerns me. There are medical  
16 decisions being taken by people who are not medically  
17 trained, nor are their so-called experts being consulted.  
18 This is my major point.

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21 (Page 1748 follows)  
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1 THE COMMISSIONER: Well, this has been  
2 very interesting, Doctor, to me, at least. I appreciate  
3 it very much.

4 MR. GUTHRIE: I am not going to venture  
5 very far into the questions, Mr. Commissioner, because  
6 I think the brief has been very helpful and informative  
7 but there are one or two things that did occur to me.  
8 The Commissioner asked you if when emphysema was found  
9 in association with silicosis if that was something  
10 dealt with by your Referee Board and you indicated that  
11 it would be.

12 DR. SUTHERLAND: Yes.

13 MR. GUTHRIE: I wondered if that was also  
14 the case where tuberculosis is found in association with  
15 silicosis.

16 DR. SUTHERLAND: That is also considered  
17 an integral part of the silicosis process so we would  
18 view it so.

19 MR. GUTHRIE: So you look at emphysema or,  
20 let us say, dust types of emphysema and tuberculosis as  
21 part of silicosis generally. I am wondering if the  
22 absence of those two diseases in Schedule 3 is causing  
23 any prejudice in your view or if you view them as if they  
24 really were there as part of silicosis.

25 DR. SUTHERLAND: It doesn't cause prejudice,  
26 I don't think.- not because they are not specified in  
27 Schedule 3. That doesn't cause prejudice because the  
28 section which deals with the disease peculiar to a  
29 characteristic of a trade or occupation enables these  
30 conditions to be compensated if one can provide evidence







1 to show that the man in a particular occupation, in fact,  
2 does have an increase in respiratory conditions. We  
3 use this for lung cancer in a number of industries, we  
4 show a greatly excessive hazard of lung cancer in  
5 certain occupations so the condition was accepted as  
6 peculiar to these occupations and compensation arranged.

7 The same can apply for emphysema under  
8 this so-called blanket clause.

9 MR. GUTHRIE: Those occupations you refer  
10 to in the lung cancer portion were not mining occupations,  
11 I take it?

12 DR. SUTHERLAND: No, they were not.

13 MR. GUTHRIE: Looking at page 4 of your  
14 submission, Doctor, just at the top of the page where  
15 you have been quoting The Honourable Mr. Justice Roach  
16 and you added by way of comment:

17 "To the industries which produce silica  
18 dust in excessive quantities you might  
19 add the manufacture or use of silica  
20 brick, as in steel-making, the spraying  
21 of vitreous enamels, and the making of  
22 certain abrasive cleansers."

23 I am wondering, are you suggesting that  
24 this is a matter that would require some elaboration  
25 of the processes mentioned in Schedule 3 for silicosis?  
26 Is that your intention?

27 DR. SUTHERLAND: No, I felt this had to be  
28 added to complete the list. These are done with the  
29 hazardous trades. We get cases of silicosis from these  
30 occupations and these cases are handled the same as any



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1 other applicant or claimant cases.

2 MR. GUTHRIE: I think the difficulty  
3 people on the outside have is when they see some things  
4 expressed and others not expressed they tend to think  
5 that others are excluded. You have helped to make it  
6 clear, I think, that that is not necessarily so.

7 DR. SUTHERLAND: This is quite true.  
8 I would like to say that The Compensation Board is  
9 essentially a practical organization. If a man claims  
10 to have been suffering from exposure at work from gas,  
11 vapour, solvent or whatnot, they will ask questions of  
12 people who should know and if there is any evidence to  
13 say yes this is so, they will go ahead and compensate,  
14 regardless of whether it is in Schedule 3. They can  
15 always do it under the blanket clause.

16 MR. GUTHRIE: Both your special board  
17 and the Workmen's Compensation Board rely extensively  
18 on the second impression of the definition of industrial  
19 disease?

20 DR. SUTHERLAND: Yes.

21 MR. GUTHRIE: You are not concerned with  
22 Section 3 at all?

23 DR. SUTHERLAND: Right.

24 MR. GUTHRIE: They would not be concerned  
25 with silicosis at all because I see it is mentioned in  
26 the schedule but are various workers altogether working  
27 in hospitals, jails and so on --

28 DR. SUTHERLAND: Yes, I didn't realize  
29 the significance, I see your point.

30 MR. GUTHRIE: Dealing with Dr. Schepers





1 just for a moment, I think you really answered the  
2 question I had in mind about him, but I wondered, are  
3 his views widely known, is he generally known in this  
4 country?

5 DR. SUTHERLAND: He is very well known  
6 and a very good scientist experimentally. I think the  
7 point, perhaps, is that these experiments, these results,  
8 have to be interpreted by people who know something  
9 about the subject under investigation. Dr. Schepers  
10 presented those reports to a medical audience essentially.  
11 And they are published in medical literature. I think  
12 it is rather difficult for the average layman to pick  
13 it up and simply take out sections which he feels apply  
14 and sort of apply these things to that. This is the  
15 one qualification that I would make.

16 MR. GUTHRIE: I think there were two  
17 possible features of his work that we should bear in  
18 mind. As I understood you, one was that he was working  
19 with animals and in animals the forms of emphysema may  
20 be different from those in humans and, secondly --

21 DR. SUTHERLAND: The forms of emphysema  
22 he produced were really secondary to other conditions  
23 in the lung, rather than a primary emphysema such as  
24 we are really concerned with here today.

25 MR. GUTHRIE: And the second thing I  
26 think you said was that the method of induction by an  
27 injection rather than by an inhalation of dust differed  
28 from the human experience.

29 DR. SUTHERLAND: This is an artificial  
30 method of getting dust into the lungs.







1 MR. GUTHRIE: Doctor, to leave the purely  
2 medical questions, could I just ask you one or two  
3 things about your Environmental Health Branch? We  
4 heard yesterday in the brief of the Steelworkers which  
5 you have read, I think, a recommendation that that  
6 branch might properly be brought within the sphere of  
7 The Workmen's Compensation Board and taken to the  
8 Department of Health. I don't ask you to comment on  
9 that, but I wonder could you tell us, first of all,  
10 is the work of that branch restricted to industrial  
11 medicine, if that is the proper description, or does it  
12 go to other non-industrial things, things such as  
13 motor car exhaust industries and so on or is it all  
14 what we might call very broadly, accident prevention  
15 work, and The Workmen's Compensation work?

16 DR. SUTHERLAND: I had understood that  
17 the comment would be made on that portion of this brief  
18 when the subject of accident prevention was to be dis-  
19 cussed and, perhaps, one of my staff will be here to  
20 discuss this. If you wish to discuss it now, I am quite  
21 prepared to.

22 MR. GUTHRIE: No, I didn't realize that  
23 was intended. That would be fine.

24 DR. SUTHERLAND: Counsel for the  
25 Commission indicated they would ask a doctor from our  
26 branch to appear to talk on the subject of accident  
27 prevention.

28 MR. GUTHRIE: You would prefer to leave  
29 it to him?

30 DR. SUTHERLAND: I would like to answer



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1 your question to indicate that, yes, our branch does  
2 have responsibility not only for occupational health,  
3 radiation, radioactivity, that is, air pollution,  
4 pesticides control, public health engineering and  
5 sanitation. They are all combined and the branch has  
6 a total complement of about 217. The staff concerned  
7 with occupational diseases and occupational health  
8 would total possibly 60 or 70. The brief of the United  
9 Steelworkers certainly left a very erroneous impression  
10 as to the work that our Branch does. The figures that  
11 they quote from The Workmen's Compensation Board's  
12 report in British Columbia are the minimal figures in  
13 comparison with the amount of work that our Branch is  
14 presently turning out.

15 THE COMMISSIONER: Well, will Dr.  
16 Mastromatteo have that information when he comes?

17 DR. SUTHERLAND: He will have full in-  
18 formation on this.

19 THE COMMISSIONER: We have before us an  
20 indication of what has been done in B.C. apparently  
21 and certainly by contrast it looks pretty small.

22 DR. SUTHERLAND: Well, the gentleman who  
23 prepared that report visited my office for one hour  
24 or an hour and a half, I had difficulty in keeping him  
25 and it is quite apparent to me that he read the  
26 Workmen's Compensation Board reports probably across  
27 Canada and only in British Columbia is the laboratory  
28 which is used for investigating occupational exposures  
29 within the Compensation Board; in other provinces it  
30 is usually within the Department of Health or the





1 Department of Labour. The gentleman who submitted the  
2 report did not read the annual reports of the Department  
3 of Health for this Province.

4 MR. GUTHRIE: Just one other thing,  
5 Doctor --

6 THE COMMISSIONER: Would it be fair to  
7 ask you your opinion about whether it should be under  
8 the Workmen's Compensation Board? I won't ask the  
9 question.

10 MR. GUTHRIE: Apart from accident pre-  
11 vention the steelworkers did as a second ground for  
12 their recommendations, suggest that if your branch  
13 were within the Board it might be of assistance in  
14 the claims adjudication procedure. I am wondering if  
15 you can say whether or not you are now providing  
16 assistance to that department, is there a liaison or  
17 to what extent is there a liaison to the Board?

18 DR. SUTHERLAND: Dr. Powell works  
19 approximately 80 percent full time on Referee Board  
20 work. This is consideration of silicosis claimants. I  
21 spend approximately two half days a week, Dr. Auerback  
22 likewise, this is on the average, Dr. Mastromatteo  
23 spends a full day at the Workmen's Compensation Board  
24 going over claims for various other industrial conditions  
25 referred to him. He probably has the keenest knowledge  
26 of working conditions and their effect on people of  
27 any medical person in Canada today and I would put him  
28 up against the best in the United States. So that the  
29 Board is getting advice from people who should know  
30 what the effects of various working conditions are on







1 health.

2 MR. GUTHRIE: Thank you very much indeed,  
3 Doctor.

4 THE COMMISSIONER: To go back to your  
5 report, there is only one thing. Referring to the  
6 report of Mr. Justice Roach in which he puts,  
7 I judge, in Section 3 in connection with silicosis -  
8 "Industries in which the workers are suffering from a  
9 disease -- mining, sandblasting, porcelain making  
10 and so on", to which you would add manufacturing  
11 silica brick in the steel-making industry, are you  
12 suggesting any change in column 2 of the Schedule 3  
13 having regard to silicosis or is that adequate as it  
14 stands?

15 DR. SUTHERLAND: I don't personally see  
16 the necessity of putting it in Schedule 3, as the  
17 cases are being handled properly or handled just as  
18 in the other cases at the moment, silicosis whether  
19 it is Schedule 3 or not. As I say, the Board is  
20 practical. Whether these refinements are necessary  
21 in the Schedule, I would not care to express an opinion.

22 THE COMMISSIONER: All right, thank you.

23 MR. GUTHRIE: Mr. Commissioner, in line  
24 with your comment to Dr. Swanson's testimony, I wonder  
25 if anyone present might like to ask a question of Dr.  
26 Sutherland?

27 MR. THIBAUT: I am not quite clear on  
28 one point but, referring back to Dr. Schepers' report,  
29 I gather that because of the method used in the report  
30 for inducing the aluminium dust into the lungs, because





1 of that method did you regard the experimental result  
2 as completely valueless or did you attach some profitable  
3 benefit to the experiment itself? This is what I  
4 want to be clear on.

5 DR. SUTHERLAND: It was not aluminium  
6 that was introduced nor was it silica. We had a whole  
7 series of reports dealing with cadmium, cobalt and  
8 several others. We ran through a whole series of  
9 reports in this particular issue - cadmium, cobalt,  
10 cobalt dioxide, cobalt metal, tungsten metal, tungsten  
11 carbide combined with carbon, tungsten carbide combined  
12 with cobalt - this was the group of figures which were  
13 mentioned.

14 MR. THIBAUT: He did use aluminum dust  
15 as a part of the experiments possibly, but irrespective  
16 of whether they use aluminum dust, nevertheless he  
17 tried to determine if these items created --

18 DR. SUTHERLAND: Mr. Thibault, as I  
19 have indicated I have used this method myself as a  
20 screening method. When the bauxite fume developed  
21 in the Niagara Peninsula back in the late 1940's, this  
22 was the very first thing we did was to gather the  
23 fume from the plant and inject<sup>it</sup> into the trachea of  
24 guinea pigs, we used actually. As I say, this is a  
25 rather coarse method of experimentation to take the  
26 results of that kind of experiment in a different species  
27 or none at all. To try to apply it to humans is taking  
28 too big a jump. You have to, I think, take it a stage  
29 further and expose the animals to bauxite dust as  
30 the human would to see whether they would then, in fact,





1 develop the condition that you are looking for. This  
2 is the only point I make. This is essentially a good  
3 screening method, but it does not represent anything  
4 like what happens to a man in industry where you come  
5 along and push, say, 50 to 150 milligrams into the  
6 windpipe of a very small animal. This is a large dose.  
7 He is a good man but he was not, I don't think, expect-  
8 ing labour or management to pick this up and then try  
9 to build a case on it; he was presenting this to a  
10 group of other scientists who would then take this  
11 as the next step and define experiments to actually  
12 see whether it is possible to show that these  
13 things could, in fact, affect humans. Why produce a  
14 disease to simulate what humans suffer from?

15 MR. THIBAUT: He did stress the lack of  
16 research and recommended more research.

17 DR. SUTHERLAND: There is lots more  
18 research required.

19 THE COMMISSIONER: Any more questions?

20 MR. YOUT: Mr. Commissioner, I believe  
21 yesterday it was stated or inferred that the environ-  
22 mental health branch only investigated problem areas  
23 upon requests of other government departments. I  
24 wonder if you or Counsel would ask Dr. Sutherland if  
25 this is true, and if that ---

26 THE COMMISSIONER: I am quite sure Dr.  
27 Sutherland will not only tell us that but we will get  
28 it as well from Dr. Mastromatteo.

29 DR. SUTHERLAND: No, we consider our  
30 primary responsibility here is to ensure that working







1 conditions are healthy. We are not an enforcement  
2 agency. The enforcement agency usually is the Depart-  
3 ment of Labour or the Department of Mines and we act  
4 as consultants to them.

5 THE COMMISSIONER: Do you undertake  
6 investigations on your own initiative or is it usually  
7 only when you are asked by one of the other departments?

8 DR. SUTHERLAND: If I could just give you  
9 a few instances. The investigation of lung cancer  
10 in a large industry, in fact the nickel refinery at  
11 Port Colborne was undertaken strictly on our own  
12 initiative. We had seen what had happened in Great  
13 Britain, so on our own, went to the company and tried  
14 to find out whether in fact they had a similar exper-  
15 ience.

16 THE COMMISSIONER: Obviously, you can do  
17 it on occasion. Generally speaking, in your practice,  
18 I suppose you are short handed, you feel you should  
19 work with somebody else?

20 DR. SUTHERLAND: We are never waiting.  
21 The point is simply to fill requests. We, for instance,  
22 are surveying the lead industry, the battery industry  
23 as far as lead exposure is concerned on our own at the  
24 present time. Last year we concentrated on mercury  
25 exposures in about 25 plants without waiting to be  
26 asked. Now, if as a result of this kind of survey --

27 THE COMMISSIONER: Perhaps you might give  
28 us some indication of how much is on your own and how  
29 much is at the request of other departments. I think  
30 you have probably answered the question.





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1 MR. YOURT: Yes, thank you.

2 THE COMMISSIONER: Is that all? Thank  
3 you, Doctor.

4 Well, we will adjourn for a few minutes.

5  
6 ---Short recess.

7  
8 MR. GUTHRIE: Mr. Commissioner, we also  
9 have here today the representatives of The Provincial  
10 Federation of Ontario Professional Fire Fighters who  
11 would like to deal with that part of their brief which  
12 relates to industrial disease.

13 THE COMMISSIONER: There **is something else.**  
14 Is Dr. Patterson to give evidence?

15 MR. GUTHRIE: On Thursday, sir.

16 THE COMMISSIONER: And he is on the same  
17 matter as we have heard Dr. Sutherland on emphysema  
18 and similar matters?

19 MR. GUTHRIE: Yes, sir.

20 THE COMMISSIONER: Right.

21 MR. HATHERSALL: I will try to be as brief  
22 as possible.

23 THE COMMISSIONER: Don't worry.

24 MR. HATHERSALL: I would like to thank  
25 you for putting me on now. I will do this as quickly  
26 as possible. I would like to read the brief and then  
27 submit several comments.

28 Occupational Hazards

29 In the submission of this Brief by the  
30 Provincial Federation of Ontario Professional Fire  
Fighters, it is intended to place before you a matter





1 which has given grave concern to the Federation over  
2 a period of years, namely, the serious occupational  
3 hazard peculiar to professional Fire Fighters in the  
4 performance of their duties, resulting in an increas-  
5 ing number of cases of injury or death from arterial  
6 hypertension, heart or respiratory disease.

7 In this connection the Federation wish  
8 to refer Your Lordship to a paper on 'firefighting and  
9 Heart Disease' by Dr. Nathaniel E. Reich, published  
10 in 'Diseases of the Chest' the official journal of  
11 the American College of Physicians, Volume 24, No. 3  
12 (Page 304), September, 1953. This article is repro-  
13 duced in full in this Brief. The Federation would  
14 draw your attention to Dr. Reich's summary of his  
15 conclusions in the article.

16 Summary

17 "1. Hypertension Coronary Thrombosis -  
18 the anginal syndrome and manifestations  
19 of accelerated atheromatous changes are  
20 especially prone to occur in firemen and  
21 related dangerous occupations because of  
22 certain mental and physical factors  
23 associated with these occupations.

24  
25 2. Adequate experimental and clinical  
26 evidence has been accumulated to show  
27 that the stresses and strains of fire-  
28 fighting, environmental extremes, trauma  
29 and shock, burns, gases and smokes, may  
30 act as predisposing factors in the caus-







1 ation of several cardiac disorders.

2 3. Aggravation of pre-existing heart  
3 disease may also occur in the presence of  
4 the above factors."

5  
6 In submitting the Brief, the Federation  
7 is not unmindful of the existing legislation in the  
8 Province of Ontario, which by amendment in 1963 pro-  
9 vided that the term "accident" as used in the Act  
10 includes "disablement arising out of and in the course  
11 of employment". The Federation recognizes the fact  
12 that where Fire Fighters die or are disabled arising  
13 out of and in the course of employment some form of  
14 compensation is provided for them under the Workmen's  
15 Compensation Act. The real concern on behalf of the  
16 Federation and its members is that in a large number  
17 of cases, if not a majority of cases, it is extremely  
18 difficult, if not impossible, to establish that the  
19 Fire Fighter suffered arterial hypertension, heart or  
20 respiratory disease arising out of and in the course  
21 of his employment. Indeed, it is a very difficult  
22 and neat question even for medical experts to determine  
23 that the disablement or decease of the Fire Fighter  
24 arose out of and in the course of his employment and  
25 this, notwithstanding the fact that a large number of  
26 studies, in fact all of the studies which the Federa-  
27 tion has been able to discover and study, clearly  
28 establish that Fire Fighters have the highest standard-  
29 ized relative index of mortality for the principal  
30 cardio-vascular diseases.





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1                   The Federation wishes to refer Your  
2 Lordship to a study made by Dr. E. Mastromatteo of  
3 Toronto, published in the American Medical Association  
4 Archives of Industrial Health, September 1959, Volume  
5 XX, pp 227 - 233. A copy of this study is separate to  
6 the brief.

7                   I would like to read just a paragraph  
8 out of the conclusion and then I will file the brief  
9 with Your Lordship.

10                   "Summary and Conclusions"

11                   This was made by Dr. Mastromatteo and  
12 was published in Archives of Industrial Health,  
13 September 1959, Volume XX, pp 227 - 233:

14                   "In a study of city fire fighters covering  
15 the period 1951 to 1953, the number of  
16 deaths observed from **certain** causes  
17 was compared with that expected using  
18 Ontario death rates for a man of similar  
19 age groups and for the same period. This  
20 comparison revealed a highly significant  
21 excess of cardio-vascular real deaths  
22 mong city firemen with a reduction in  
23 respiratory and tuberculosis deaths. '

24                   And this is all I will read. I would  
25 like to file this with you, sir, as Exhibit 22.

26  
27 ---EXHIBIT NO. 22: Summary and Conclusions made by  
28 Dr. Mastromatteo published in  
29 Archives of Industrial Health,  
30 September 1959.



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1 M. HATHERSALL: The medical profession  
2 generally has recognized for many years that arterial  
3 hypertension, heart and respiratory diseases are  
4 extremely realistic occupational hazards for Fire  
5 Fighters. Occupational hazards can be divided into  
6 two classifications. The first of these, injury, is  
7 usually obvious. A Fire Fighter breaks his leg or arm,  
8 has it treated and eventually returns to duty. There  
9 is rarely any question that the injury was related to  
10 his work, that he was disabled as a result of this  
11 work and is entitled to compensation. The second  
12 disease, is much less obvious. Either disease or  
13 injury may be primary or secondary. The primary dis-  
14 abling conditions are those that are wholly due to fire  
15 department activity. The secondary are those which  
16 have been aggravated by such activity.

17 In this connection we draw your attention  
18 to the prevalence of special legislation throughout  
19 the United States of America and other parts of Canada  
20 which has the effect of protecting Fire Fighters and  
21 assisting them in having this occupational hazard  
22 recognized in settlement of claims for disablement  
23 or death from these diseases. All of these enactments  
24 have the effect, in varying degrees, of creating a  
25 presumption in the case of Fire Fighters who suffer  
26 disablement or death from these diseases, that the  
27 disablement or death from these diseases arose out  
28 of and in the course of the Fire Fighters' employment.  
29 For your information there is attached to this brief  
30 copies of a large number of these enactments from





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various jurisdictions, and these start on Page 16 and run through to page 35.

The Honourable W.F.A. Turgeon, P.C., dwelt at some length with respect to a disablement, by reason of the work the employee was called on to do. For your convenience and information a partial text of that report is reproduced below taken from page 52: In this connection His Lordship is speaking of the definition of "accident" as it appears in the Alberta Act:

"I think this definition of "accident" is particularly useful in what it says about disablement, because experience shows that a man may become disabled in some part of his physical structure by reason of the work he is called upon to do. Instances of this have been found in the case of workmen employed for long periods in the guidance and control by hand of pneumatic drills which produce violent vibrations causing eventually a total or partial inability in the workman to use his arms for normal working purposes. When this condition has become fixed and ascertained, the workman is in the same position as if his whole or partial disablement had been brought on by an accident occurring at that particular time.

"Bordering on this kind of case although





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1 not wholly assimilable to it, is the  
2 condition of the workman who has, by reasons  
3 of a defective physical condition, a  
4 pre-disposition to injury or death  
5 arising out of the nature of his employ-  
6 ment. An instance of this kind is to be  
7 found in the American case of Town of  
8 Cicero vs. Industrial Commission (Supreme  
9 Court of Illinois (1949) 404 Ill.487,  
10 89 N.L. 2d, 354)

11 "In this case one Miller, lieutenant in  
12 the fire department of Cicero, had  
13 suffered from heart disease (chronic  
14 myocarditis) for at least five years  
15 prior to his death. He had been advised  
16 by his physician that he should quit his  
17 job because it was too strenuous for him.  
18 On the morning of January 22nd, 1946 a  
19 fire occurred at a restaurant near the  
20 station where he was on duty. He rushed  
21 to the fire by truck, ran into the  
22 building and began directing his men in  
23 the extinguishment of the fire. Suddenly  
24 he fell to the floor, was taken to a  
25 hospital and was found to be dead. In  
26 disposing of the case the court said that  
27 the rule to be followed, was 'that if a  
28 workman's existing physical structure,  
29 whatever it may be, gives way under the  
30 stress of his usual labour, his death is



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1 an accident which arises out of his  
2 employment.'

3 The judgment then proceeds to hold:

4 'In the instant case, the fact that Miller  
5 was suffering from chronic myocarditis,  
6 predisposing him to collapse and death  
7 is of no consequence. Whether he might  
8 have died in the same way in the absence  
9 of any exertion at all, while sitting  
10 in his own home, or whether he might  
11 have suffered collapse if he had stayed  
12 at home and not worked that day is  
13 immaterial. The question for the  
14 Commission was whether the work he was  
15 doing in connection with fighting the fire  
16 caused, or contributed to cause his  
17 collapse and death' ''.

18 THE COMMISSIONER: Since that particular  
19 case, have you had any incidences of cases where the  
20 circumstances were similar to that that have come  
21 before the Board?

22 MR. HATHERSALL: Yes.

23 THE COMMISSIONER: And did the Board  
24 award compensation?

25 MR. HATHERSALL: Yes.

26 THE COMMISSIONER: I would have thought  
27 they would. It is the marginal case that you are  
28 worrying about?

29 MR. HATHERSALL: Yes, we have had four  
30 or five cases which, London and certain places.

The Provincial Federation of Ontario







1 Professional Fire Fighters bring to your attention an  
2 addition to the Manitoba Act made and done at a regular  
3 meeting of the Workmen's Compensation Board of Manitoba  
4 held on the fourteenth day of July, A.D. 1966. Quote:  
5 And here, I would like to introduce the new regulation  
6 contained in the Manitoba Act which I only received  
7 today and which is not the same as I have printed here.  
8 To save some time here, I won't read the regulations.  
9 It is very similar to the one I have in the brief.  
10 I would just like to bring it to your attention and  
11 read the preamble which now precedes the Act.

12 "This regulation sets out certain pre-  
13 sumptions to be applied to claims involv-  
14 ing fire fighters and these presumptions  
15 are additional to the basic right of  
16 every applicant workman to have his claim  
17 determined upon its real merits and  
18 justice and facts of his case."

19 This is changed slightly in the paragraphs  
20 01.00 and 02.00 and 03.00, 04.00 and 05.00 are iden-  
21 tical.

22 MR. GUTHRIE: I think it would be helpful  
23 if you were to read the new form, Mr. Hathersall.

24 THE COMMISSIONER: Why not read this  
25 and let us have it.

26 MR. HATHERSALL:

27 "Schedule"

28 "Manitoba Regulation /66

29 "Manitoba Workmen's Compensation Board  
30 Regulation 1/66 - Made Under



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The Workmen's Compensation Act R.S.M. M.  
1954, C297 respecting

Full-time Municipal Fire Fighters

"01.00 In this regulation "fire fighter"  
means a full-time member of a  
professional fire-fighting depart-  
ment.

02.00 Where a fire fighter suffers a  
heart attack diagnosed as such  
by a duly qualified medical  
practioner.

(1) after he has entered upon and while  
he is still engaged in the actual  
answering of a fire call and the  
fighting of a fire; or

(2) while he is actually engaged upon  
prescribed training phases of his  
work involving substantial physical,  
mental or nervous tension or strain; and

(a) the firefighter during the two  
years immediately preceding  
any occurrence upon which a  
claim is based, has been in  
continuous service as a member of  
the department.

(b) at or after the time entering  
such service the fire fighter  
has undergone a physical examination  
including an examination of the cir-  
culatory system (if such an examina-





tion is required by the employing department), following which examination he was duly approved for service as a fire fighter; unless the contrary is proved, the injury shall be deemed to have been suffered in the line of duty and to have arisen out of and in the course of his employment.

"03.00 A fire fighter who has had a heart attack, whether compensable or not, but has thereafter been medically certified to be fit for service as a fire fighter, is entitled to the benefits of Section 2, hereof.

"04.00 A fire fighter who becomes disabled by reason of lung injury is, unless the contrary is proved, deemed to have incurred the disability in the course of and arising out of his employment if the type of lung injury by which he is disabled is generally accepted in medical opinion as resulting from the inhalation of smoke or gases, or fumes, or any two or more of these causes.

"05.00 Where disability due to inhalation of carbon monoxide is claimed,







1 Section 4 applies only where a  
2 medical ruling of inhalation of  
3 and disability by reason of the  
4 inhalation of carbon monoxide is  
5 made within forty-eight hours of  
6 the exposure claimed as the cause  
7 of the disability."

8 I will now go on with the brief. The  
9 foregoing, Manitoba Workmen's Compensation Board  
10 Regulation 1/1966, provides protection for Fire  
11 Fighters who become disabled as a result of an aggra-  
12 vation of a pre-existing cardio-vascular or respiratory  
13 disorder. The effect of the regulation, we submit,  
14 is that it creates a presumption and places the onus  
15 on the Board rather than the Fire Fighter to rebut the  
16 evidence. It is our submission, Your Lordship, that a  
17 similar provision be made available for the professional  
18 fire fighters in the Province of Ontario. With this  
19 we respectfully rest our case with you.

20 THE COMMISSIONER: Any questions?

21 MR. GUTHRIE: Mr. Hathersall, have you  
22 had any similar experiences in other jurisdictions  
23 affecting presumptive regulations of that sort?

24 MR. HATHERSALL: No, except in the  
25 United States but not in Canada.

26 MR. GUTHRIE: This is the break through?

27 MR. HATHERSALL: Yes.

28 MR. GUTHRIE: And that was passed just  
29 recently as when?

30 MR. HATHERSALL: September 28th of this



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1 year.

2 MR. GUTHRIE: We heard this morning  
3 and yesterday the recommendations of the Mine Mill  
4 Union and the Steelworkers Union of Mr. Justice  
5 Roach's previous recommendation about pre-existing  
6 conditions that should be again revised. I wonder  
7 if you would have any comment on whether his approach  
8 to the thing would be of assistance to your Associa-  
9 tion. Do you recall that?

10 MR. HATHERSALL: I am not really qualified  
11 to answer that. I read Mr. Justice Roach's report  
12 but I am not really qualified to elaborate on it.

13 MR. GUTHRIE: He recommended that a  
14 section be added to the Act in these terms:

15 "Where an accident causes an injury to  
16 a workman and that injury is aggravated  
17 by some pre-existing physical condition  
18 inherent in the workman at the time of  
19 the accident, the workman shall be  
20 compensated for the full injurious  
21 result."

22 Now, that is not quite the same as a  
23 presumption such as might be gained by a Schedule 3  
24 situation?

25 MR. HATHERSALL: No, we have had situa-  
26 tions where the Board have awarded for heart or lung  
27 disorders and then based the award on a pre-existing  
28 condition. And I have to go back some years for this.  
29 I can recall one man who suffered a heart attack  
30 but because of a pre-existing condition they reduced





1 the award and the rub was this: They reduced the  
2 award on the pre-existing condition but when he died  
3 his widow did not claim the widow's pension because  
4 of the pre-existing condition. We have argued all  
5 over the years that at least his widow should have got  
6 the \$75.00 a month or a proportion of that amount.

7 MR. GUTHRIE: Or at least the same  
8 proportion that it had been reduced by in the first  
9 place?

10 MR. HATHERSALL: Yes.

11 MR. GUTHRIE: Why was no claim made  
12 in the first place?

13 MR. HATHERSALL: Well, the Board said  
14 he had died of something other than what had caused  
15 the original disability and from there on we were up  
16 a dead end street.

17 MR. GUTHRIE: In his lifetime, do you  
18 remember what percentage of award was made? By how  
19 much was he reduced by the pre-existing condition?

20 MR. HATHERSALL: This was in 1952 and  
21 his award was \$78.00 a month. Now, what relation that  
22 has to 1952 I have no idea. The case is old now.

23 MR. GUTHRIE: You did mention some other  
24 cases that you called marginal, like the Cicero  
25 fireman but others you had in mind. Can you give us  
26 some examples of what you consider marginal cases and  
27 how a board has dealt with them?

28 MR. HATHERSALL: We have had some awarded  
29 and some rejected because we couldn't relate the dis-  
30 ability to an incident. The problem with our people







1 is this, that over the years or over the course of  
2 employment it is hard to find one specific instance  
3 where the man was overcome, he didn't bother reporting,  
4 he didn't go to his officer and say something, so we  
5 have had them turned down and allowed. We are on about  
6 a 50/50 basis in this respect.

7 MR. GUTHRIE: The rejections, though,  
8 have largely been in cases where it was not an  
9 incident.

10 MR. HATHERSALL: If we can get the man  
11 to drop dead at the scene of the fire we are home free,  
12 but otherwise it is difficult for us. So, in this  
13 case, we would like the presumptive provision in there.

14 MR. GUTHRIE: Have you approached this  
15 from the standpoint of including an item in Schedule  
16 3 of the Ontario Act?

17 MR. HATHERSALL: Yes.

18 MR. GUTHRIE: As opposed to this idea  
19 of a special regulation?

20 MR. HATHERSALL: Yes, this is what we  
21 would like to have. It is something similar to the  
22 presumption here so that the man's representative  
23 doesn't have to rebut the evidence. If he drops dead  
24 at a fire he is covered, even though he might have a  
25 pre-existing condition.

26 MR. GUTHRIE: I think we have your point,  
27 Mr. Hathersall.

28 THE COMMISSIONER: I would like to ask  
29 you: Do you have medical examinations now?

30 MR. HATHERSALL: Yes.





1 THE COMMISSIONER: Periodical?

2 MR. HATHERSALL: There are a few depart-  
3 ments who do have periodic medicals and Toronto is one  
4 of them. Mind you, this is subject to the man's  
5 consent. He doesn't have to.

6 MR. IRELAND: In most instances it is not  
7 compulsory.

8 MR. GUTHRIE: Are these pre-employment or  
9 during employment?

10 MR. IRELAND: During employment also.

11 MR. GUTHRIE: What is your own view about  
12 the desirability of those examinations, do you think  
13 they should be made compulsory or on a voluntary basis?

14 MR. HATHERSALL: This is something that  
15 came up, that has always been a bone of contention  
16 with our people. They come on the job, they are healthy  
17 and young, we have an age limit, some ages are down as  
18 low as 25. They have a physical examination and they  
19 come on good and then after ten or fifteen years they  
20 start to drop off. Whether it is the cumulative affect  
21 of carbon monoxide I don't know. I am not prepared  
22 to say whether there should be annual medical examina-  
23 tions. They have introduced them in some departments  
24 within our Union.

25 MR. GUTHRIE: Is there any such require-  
26 ment in Manitoba?

27 MR. HATHERSALL: I can't tell you that.

28 THE COMMISSIONER: Thank you.

29 MR. GUTHRIE: Mr. Commissioner, Dr.  
30 Powell of the Board and Dr. VanNostrand who is with  
him would like, if it is convenient at this point, to





1 deal with one aspect of this morning's evidence and  
2 that is the question of psychoneurosis. It would  
3 permit Dr. Van Nostrand to get away if we could  
4 approach that now and deal with the rest of the  
5 Board's presentation at a later time.

6 THE COMMISSIONER: Very well.

7 DR. POWELL: Mr. Commissioner, I am  
8 Dr. Powell of the Compensation Board and I have with  
9 me Dr. F.H. VanNostrand, a neuropsychiatrist and a  
10 consultant to the Board.

11 I would like to outline our current  
12 management of patients suffering from mental disorders.  
13 Patients suffering, first, from psychosis. Psychosis  
14 is a term applied generally to any kind of mental  
15 disorder, especially those groups in which the disorder  
16 is more serious and characterized by lack of insight  
17 as distinct from psychoneurosis. These include  
18 patients who are presumed sane, but have histories of  
19 psychiatric treatment for serious mental illness prior  
20 to their accident. There are four major groups.

21 Psychosis from Brain Damage

22 Patients whose personality disorder is  
23 the direct result of the compensable injury. Most of  
24 these are the result of brain damage following trauma.  
25 There has been recovery, but not complete. The Board  
26 is responsible for treatment, payment of compensation  
27 and permanent disability awards. The decision as to  
28 the advisability of continuing treatment at the  
29 Hospital and Rehabilitation Centre or transferring  
30 such patients to another hospital is made by the Head







1 Injury Committee and the system is working well.

2 Mental Impairment

3 Mental impairment with or without  
4 psychosis associated with brain damage caused by  
5 external agents, by endogenous toxins or specific  
6 disease such as toxic chemicals used in industry, high  
7 voltage current, Caisson disease, and cerebral anoxemia.  
8 On the basis of the psychiatrist's or neurologist's  
9 report, the benefits of the Act are awarded which  
10 include treatment entitlement with payment of compensa-  
11 tion and permanent disability awards.

12 Mental Impairment Resulting from the Accident

13 Patients who show little clinical or  
14 other objective evidence of brain damage and where it  
15 can be concluded from the evidence that the mental  
16 illness has been produced or precipitated by the  
17 accident are entitled to benefits. Such a case might  
18 arise where a workman was buried in a cave-in.

19 Reactive Depressions

20 Patients who have not suffered brain  
21 damage may develop severe reactive depressions follow-  
22 ing prolonged invalidism or progressive conditions.  
23 A few of these have little to look forward to and are  
24 potential suicidal risks and may be, on the evidence,  
25 entitled to compensation.

26 Where Psychosis is not Related to Compensable Injury

27 Those suffering from schizophrenia,  
28 manic depressive psychosis or other endogenous  
29 mental illnesses usually have a history of repeated  
30 admissions to mental hospitals. These may be referred





1 to Ontario Mental Hospitals or to psychiatric services  
2 of general hospitals. These patients have entitlement  
3 for their compensable accident condition, but no  
4 provision for permanent disability for the psychosis.

5 I would like to go on now to mention  
6 psychoneurosis.

7 THE COMMISSIONER: Just a minute. These  
8 patients have entitlement for their compensable accident  
9 condition, not provision for permanent disability.  
10 There has been an accident in this case, has there?

11 DR. POWELL: Yes, sir, they are treated  
12 for the accident but they are mental.

13 THE COMMISSIONER: But it is considered  
14 that this is a previous condition that they had and  
15 you are not providing permanent disability for the  
16 condition itself?

17 DR. POWELL: That is correct.

18 THE COMMISSIONER: I think I understand  
19 that.  
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1 DR. POWELL: Just on the past history.

2 Psychoneurosis may be definted as a  
3 functional disease of the nervous system unaccompanied  
4 by any demonstrable structural changes. A diagnostic  
5 differentiation between the psychotic and the psycho-  
6 neurotic is a field in which not even the expert  
7 would claim infallibility. The fundamental concept is  
8 that no mind is able to withstand infinite stress  
9 without "breaking down" and producing symptoms which  
10 sooner or later are recognized as those of neurosis.  
11 Every individual has a threshold of stress beyond  
12 which his emotions are lost to his control and he becomes  
13 a victim of neurosis. Thus this threshold is con-  
14 stitutional and a pre-accident fact. Those suffereing  
15 from psychoneurosis form the largest group and are of  
16 the mixed type with anxiety and depressive features.

17 "Functional overlay" is not an entity,  
18 but is an inclusive term in common use for want of a  
19 better one. When used in this context, it includes  
20 many descriptive terms such as malingering (gross  
21 exaggeration of disability for the purpose of gain);  
22 anxiety states (reaction disproportionate to the event);  
23 hysterical reactions in a person who is constitutionally  
24 unstable; psychopathic personality with or without  
25 antisocial behaviour; alcoholism; hypochondriasis;  
26 accident neurosis; traumatic neurosis and poor  
27 motivation.

28 In this context, functional overlay does  
29 not include the insanities (committable mental ill  
30 health) whether the result of compensable injury such as  
brain trauma or not -- example - schizophrenia, severe







1 depressive reactions, either endogenous or reactive;  
2 epilepsy -- post-traumatic or idiopathic; mental  
3 deficiency.

4 Operating Policy

5 "It is axiomatic in the treatment of  
6 the psychoneurotic that hope of cure rests upon one's  
7 ability to offer the patient a greater gain than that  
8 afforded by his illness." -- D. Hubble, Lancet, 1943.

9 When the workman develops a functional  
10 overlay in relation to his compensable disability,  
11 every attempt is made by psychiatric consultation  
12 to assist the workman to overcome this critical period.  
13 Psychiatric treatment is provided concurrently if it does  
14 not prolong treatment of the compensable disability.

15 Psychoneurosis without faculty loss or  
16 measurable clinical deformity is difficult to establish  
17 with regard to entitlement and requires neuropsychiatric  
18 supervisory consultation.

19 Mr. Commissioner, should there be  
20 questions directed in this field, I think I should  
21 refer to Dr. VanNostrand, who will answer questions  
22 pertaining to this, which is his specialty.

23 THE COMMISSIONER: I don't know what  
24 questions Mr. Guthrie has. I think I have followed  
25 your summary of the situation. I am afraid I will  
26 have to give it some consideration before I am in a  
27 position to ask any questions regarding it. As far  
28 as I follow you, as far as psychosis is concerned,  
29 number one, on page one of your report, that is  
30 compensable, psychosis from brain damage?





1 DR. POWELL: Yes. That is usually no  
2 problem, sir.

3 THE COMMISSIONER: Mental impairment  
4 caused by external agents, if the external agents can  
5 be established, that is compensable?

6 DR. POWELL: Yes.

7 THE COMMISSIONER: Impairment resulting  
8 from accident?

9 DR. POWELL: In the absence of any  
10 affirmatory or clinical or laboratory evidence.

11 THE COMMISSIONER: It is hard to estab-  
12 lish a case for compensation there?

13 DR. POWELL: That is right, unless  
14 governed by the situation.

15 MR. GUTHRIE: You compensate in severe  
16 cases?

17 DR. POWELL: In severe cases, yes.

18 THE COMMISSIONER: You have made the  
19 distinction between psychosis and psychoneurosis.

20 DR. POWELL: I have tried to make an  
21 arbitrary differential between the two.

22 THE COMMISSIONER: In these cases it is  
23 the mental instability evidencing itself, making itself  
24 manifest in a different way from psychoneurosis?

25 DR. POWELL: Lack of insight as distinct  
26 from psychoneurosis. This group is not too difficult.  
27 It is the second group which poses a very difficult  
28 problem in our adjudication.

29 THE COMMISSIONER: These other cases  
30 you refer to are cases where you would have schizo-





1 phrenia, depressive reactions, or other evidence of  
2 disturbed mental condition?

3 DR. POWELL: That is right, sir.

4 THE COMMISSIONER: Psychoneurosis is a  
5 sort of anxiety condition, not a real mental condition?

6 DR. POWELL: Or mental illness, that  
7 is right.

8 THE COMMISSIONER: Supposing we use the  
9 word "hysterical" condition?

10 DR. POWELL: That is one of many:  
11 Anxiety, depression, associated with their injury,  
12 which prolongs very often their rehabilitation or  
13 prolongs their period of getting back to gainful  
14 employment.

15 THE COMMISSIONER: Apart from compensa-  
16 ting for the injury, you concentrate primarily and  
17 most importantly on time to get them back to work  
18 and trying to get them away from this anxiety?

19 DR. POWELL: Yes, by getting hold of  
20 these cases early and doing something about it. In  
21 other words, not allowing them to hang on too long  
22 without getting at the base of the trouble, and that  
23 is where we use psychiatric consultation to assist  
24 the men over this period. Probably the worst thing  
25 that can happen to a workman is the accident, and  
26 sometimes these psychiatric conditions come to the  
27 surface and this presents a problem. It creates  
28 fear of loss of his job and other things associated  
29 with it. It makes this condition come to the surface,  
30 which is really in many instances an exaggeration of







1 a normal behaviour when anyone has a difficult situa-  
2 tion confronting him.

3 THE COMMISSIONER: And, of course, in-  
4 cluded in it is malingering

5 DR. POWELL: Fortunately, that is not  
6 very common.

7 THE COMMISSIONER: Have you some  
8 questions, Mr. Guthrie?

9 MR. GUTHRIE: Not very many, sir.

10 How does the need for this sort of  
11 psychiatric treatment first come to the attention of  
12 the Board? Is it something that the general  
13 practitioner in some subsequent progress report would  
14 call for?

15 DR. VanNOSTRAND: Usually, Mr. Commiss-  
16 ioner, the psychiatric examination comes from the  
17 doctor, anyplace in Ontario. But the very brief brief  
18 that Dr. Powell has presented is really based on our  
19 experience at Downsview, to which the hard core,  
20 less than 5 percent of the total compensable cases in  
21 a year, come because they fail to respond to normal  
22 treatment outside, and the biggest obstacle to getting  
23 them back to work is this nebulous thing called  
24 functional overlay and the division between an ordinary  
25 nervousness handled by a local practitioner which  
26 accompanies any serious injury is exaggerated in  
27 patients who have a pre-disposition and ones who have  
28 had no pre-disposition, but who have had what is best  
29 described as a catastrophic industrial accident.

30 May I elaborate on this, sir?





1 MR. GUTHRIE: Please do. Would a cata-  
2 strophic type of situation be like a **cave-in** situation  
3 you spoke of?

4 DR. VanNOSTRAND: Yes, sir.

5 MR. GUTHRIE: Would this be a psychosis?

6 DR. VanNOSTRAND: Well, the catastrophic  
7 situation is the chap who falls from a height and  
8 severs his spine and his whole world collapses about  
9 him; he will never walk without those braces on him.  
10 There are not many of them at Downsview, but we see  
11 a few of them. It is particularly the young chap  
12 who is just starting life. Now, the **cave-in** illustrates  
13 another aspect of it, which in my opinion is not  
14 provided for sufficiently in the Board, and that is  
15 fear.

16 Then, the next thing, the chap who was  
17 laying a trunk sewer and water main and he was thrown  
18 down and his head was in the opening of the new sewer  
19 and he was there about an hour, possibly longer, with  
20 people digging him out, and they expected a second  
21 **cave-in**. But it was a freak accident where he had  
22 something to breath. Eight months later he had no  
23 signs of disability, but as far as he was concerned  
24 he had had it, and I don't blame him; I would never  
25 go down if that happened to me, never in my life.  
26 Now, you people know the same thing happens in a  
27 rock fall where the man is knocked out and he knows  
28 nothing about it; but if the man is covered and  
29 doesn't know how long he will be there and he comes  
30 out, he is afraid and he doesn't know why he should





1 work underground.

2 Now, about the malingerers, we see  
3 practically no malingerers practically out of the whole  
4 lot; I think I was involved with two cases in six  
5 years.

6 There is that little silly story which  
7 you all know, where the chap injured his knee at work  
8 and his daughter said he was getting better, and he  
9 was mowing the lawn on Sunday, and he said he was  
10 going back on Monday but compensation set in.

11 On the matter of seasonal work, the  
12 chap who is a concrete finisher, comes from/southern Europe,  
13 has very little aptitude, very little English, and  
14 who has an accident in December, ordinarily he goes  
15 on unemployment insurance for part of the winter,  
16 anyway, and why would he get well until somewhere  
17 around March.

18 I had a French-Canadian boy I was  
19 rather fond of, and he was quite naive. He had a  
20 disc disease, had an accident in the bush, and I said  
21 with his compensation he could still get back and cut  
22 cord and the two would work out. But he said, "I  
23 have eight kids. What will I do?"

24 Now, there is the chap in the cave-in  
25 and that chap, whose psychoneurosis, which is anxiety  
26 nearly always and depressive features, is as a result  
27 totally disabled, and not even a blow on the head.

28 MR. GUTHRIE: Can you tell us what the  
29 Board did in those cases in terms of compensation?

30 DR. VanNOSTRAND: I haven't the name,







1 but the Board placed the chap who had been in the  
2 cave-in and hadn't been asphixiated. We helped him  
3 get a job and carried on his compensation.

4 THE COMMISSIONER: There is just a  
5 question of how long it is going to be carried on.  
6 What about these situations of neurosis? You say they  
7 are entitled to compensation because they have had a  
8 nervous breakdown on the job or something like that?

9 DR. VanNOSTRAND: Yes.

10 THE COMMISSIONER: You have got a number  
11 of those, have you?

12 DR. VanNOSTRAND: Yes. May I refer to  
13 the four previous speakers today. They either  
14 obliquely or directly referred to the **constitutional**  
15 pre-disposition, vulnerability, and the disposition  
16 of the individual's reaction. Dr. Swanson spoke about  
17 the backs. Mr. Kennedy and Mr. Hall both mentioned  
18 it in their discussion **in** their argument for  
19 recognizing neuroses; and it was brought out by you,  
20 Mr. Guthrie, with the last speaker, that he had  
21 a tendency, and I haven't time to discuss that in  
22 detail. But my feeling is that at the extreme ends  
23 of the list, it is quite simple. One is that we had  
24 a chap last spring who was admitted to us at Downsview  
25 and was on parole from a mental hospital. Now, you  
26 may say that his accident precipitated or aggravated  
27 it, that he should get full compensation. To me that  
28 is wrong, sir. That man had been in and out of mental  
29 hospitals for so long. We had one who had been in and  
30 out of mental hospitals for 20 years, and he cuts his





1 fingers and he had a flare-up. Personally, I don't  
2 think that man should be pensioned for the nervous  
3 part of his condition that is totally compensable.  
4 For the damage to his finger, it wouldn't be enough  
5 to live on.

6 There is the point about neurosis, from  
7 what you said, that full compensation should be paid  
8 for the man who is disabled by his functional nervous  
9 disease, or did I mistake what you meant? Is this  
10 extraneous to what you wanted, sir?

11 THE COMMISSIONER: We have had very few  
12 submissions in connection with nervous disease, but  
13 I think there have been some to indicate that there  
14 are certain things which should be taken into consider-  
15 ation in certain occupations which are perhaps a  
16 presumption and are due to the character of the work.

17 DR. VanNOSTRAND: We have a chap who has  
18 been one of our problem cases. He developed the bends,  
19 call it what you want - Diver's disease - working  
20 underground. He wasn't air-compressed, and then he  
21 was put in an iron lung, and after two or three years  
22 one organ became useless after another and he was put  
23 in a wheelchair. He had a splendid record up until  
24 the time of his accident and he had returned to work  
25 briefly after his operation. I was called to see him  
26 because he was saving pills to suicide while in our  
27 hospital, and he later did take an over-dose and was  
28 admitted to another hospital. But the Board recognized  
29 his mental illness, that is, anxiety with depressive  
30 features, and then moving into the psychiatric side





1 and the Board accepted the total disability, the help-  
2 lessness, and even modified his house to facilitate  
3 his wheelchair existence. Now, that is a clear-cut  
4 case at one end of the list, and there are others in  
5 between.

6 The ones we have found impossible to  
7 serve are the ones with closed head injuries and who,  
8 six months or a year later, show nothing, and that is  
9 why we have this Head Injury Committee which meets  
10 every second week. The clear-cut ones, as Dr. Powell  
11 said, are the missile or rock-falling. There even  
12 was a man who cracked his head on the concrete floor,  
13 and that was accepted without question.

14 We have men in mental institutions  
15 because of the loss of half a lobe. But where the  
16 accident is well described - a year and a half later  
17 they don't return to work.

18 There is a monograph by Henry Miller,  
19 which I think Dr. Powell submitted to you, which I  
20 think is the best of its kind I know of. It is called  
21 Accident Neurosis, which isn't a very good name. It  
22 is a survey of 4,000 cases in England.

23 To come closer to home, two years ago  
24 in Baltimore, the International Association of  
25 Industrial Boards and Commission met, and several  
26 others were there. It was most interesting because  
27 the psychiatric aspect was discussed under the title  
28 of "The Emotional Reaction of the Worker and his  
29 Family to Industrial Injury." That hasn't been dis-  
30 cussed today, the reaction of the family. Very often







1 it breaks up the home. The converse there is where the  
2 injured workman, when he should be encouraged to do  
3 everything, gets too much attention at home and he finds  
4 it easier to hide behind his disability, because of  
5 the financial gain and because of the attention of his  
6 family.

7 Now, I could ramble on for hours, but it  
8 is four-thirty, and unless there are some questions,  
9 I will stop, sir.

10 MR. GUTHRIE: The only thing that occurred  
11 to me in this connection was the question of whether  
12 you have any evidence of miners showing these signs  
13 of stress and anxiety, more so than in other occupational  
14 groups. The suggestion made this morning was that a  
15 great deal may be in the mining industry and in these  
16 industries where the workers led a life of stress.

17 DR. VanNOSTRAND: I have no statistics,  
18 Mr. Guthrie. Our impressions are not very accurate.  
19 As you know, all of the industries are rated from the  
20 needle trades, where practically nothing happens except  
21 minor injuries to the heavy industries. I am speaking  
22 of the workers from the north country to Downsview, who  
23 have more serious injuries, as in the lumbering, than  
24 most others.

25 THE COMMISSIONER: You are talking about  
26 mental injury?

27 DR. VanNOSTRAND: No, I am talking about  
28 their reaction to the injury, particularly the chap  
29 in rock-fall. We have premature blasts where the  
30 injury may be slight, but it may be somebody setting





1 off a fuse where he is. I would say that the accidents  
2 from the mines are more severe than the accidents in  
3 Toronto, but we have no figures, Mr. Commissioner.

4 THE COMMISSIONER: The mental conditions  
5 in Downsview, do they seem to be more common, or are  
6 you talking about physical accidents?

7 DR. VanNOSTRAND: I am talking about  
8 their reaction and fear. Some are actually afraid  
9 to work underground again and they are loath to admit  
10 it. There is a court case here in Toronto, where there  
11 are men working under two or three atmospheres.

12 THE COMMISSIONER: Thanks very much.  
13 I think I am aware of the various considerations that  
14 have to be faced, that the unions have asked us to  
15 consider.

16 If Mr. Guthrie has nothing else, that  
17 will be all. Thank you.

18 MR. GUTHRIE: In the morning, Mr.  
19 Commissioner, Mr. Perry of The Ontario Mining Associa-  
20 tion will be available, and there will be briefs to  
21 be submitted by The United Electrical Workers. Inter-  
22 national Nickel has some comments on this point. It  
23 may be that we haven't enough to occupy us for the fu-  
24 day. I think we will just have to see how it proceeds.  
25 Mr. Koskie of The Labourers' Union is the other subject  
26 tomorrow. On Thursday, there are doctors who are  
27 scheduled to appear, and The Ontario Federation of  
28 Labour. I think we have the better part of a day's  
29 work, at any rate.  
30





*Nethercut & Young*

1790

*Toronto, Ontario*

1 THE COMMISSIONER: We will adjourn until  
2 tomorrow morning at ten o'clock.

3  
4 ---Adjournment.

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